



HLSC 3P80  
Evidence Synthesis  
Library Seminar  
February 15 2023

*Ian Gordon & Elizabeth Yates*



Ian Gordon, Teaching & Learning Librarian



Brock University Library

# This Course: HLSC 3P80 Child Health

## **Course Calendar Description:**

Exploration of the biological, psychological & sociological determinants of children's health.

## **Additional Description:**

This course will examine health and development issues among children in Canada.

It will take a complementary biopsychosocial perspective to explore both the physical and mental health aspects of children from infancy through adolescence and early adulthood.

The main goal of the course is to introduce students to a broad way of thinking about child health, integrating the biomedical model and the biopsychosocial model to [critically evaluate current policies and perceptions of health and health services.](#)

## Evidence Synthesis Library Seminar Learning Outcomes

- Understand the importance of evidence synthesis when critically evaluating health issues
- Synthesis, evaluate, communicate, and comment on child health research issues
- Note the value of different evidence synthesis reviews and where rapid reviews fit in
- How best to select appropriate scholarly databases
- The importance of thinking like each database to get the best results
- Screening results for eligibility using inclusion/exclusion criteria
- Identifying emergent themes and writing up results
- Recognize the value of zoterobib and Zotero citation management software
- Documenting findings using PRISMA reporting guidelines and references
- Knowing where and how to get help



Photo by [Tim Gouw](#) on [Unsplash](#)

# Evidence Synthesis Library Seminar Where to get Help

Brock Library Health Sciences Research Guide

<https://researchguides.library.brocku.ca/HLSC>

Library Resources for HLSC 3P80

<https://researchguides.library.brocku.ca/HLSC3P80>

Email the Library

[libhelp@brocku.ca](mailto:libhelp@brocku.ca)

Ask Us Chat service

<https://brocku.ca/library/chat/>

Ask Us Chat 

Book a Consultation

<https://calendar.library.brocku.ca/appointments/researchconsultation>

## Health Sciences

HOME

BOOKS & BACKGROUND INFO

ARTICLES

THESES & DISSERTATIONS

WEBSITES

PUBLIC HEALTH

DATA & STATISTICS

NEWS

STREAMING VIDEO

SYSTEMATIC REVIEWS &  
EVIDENCE SYNTHESIS

WRITING AND CITING

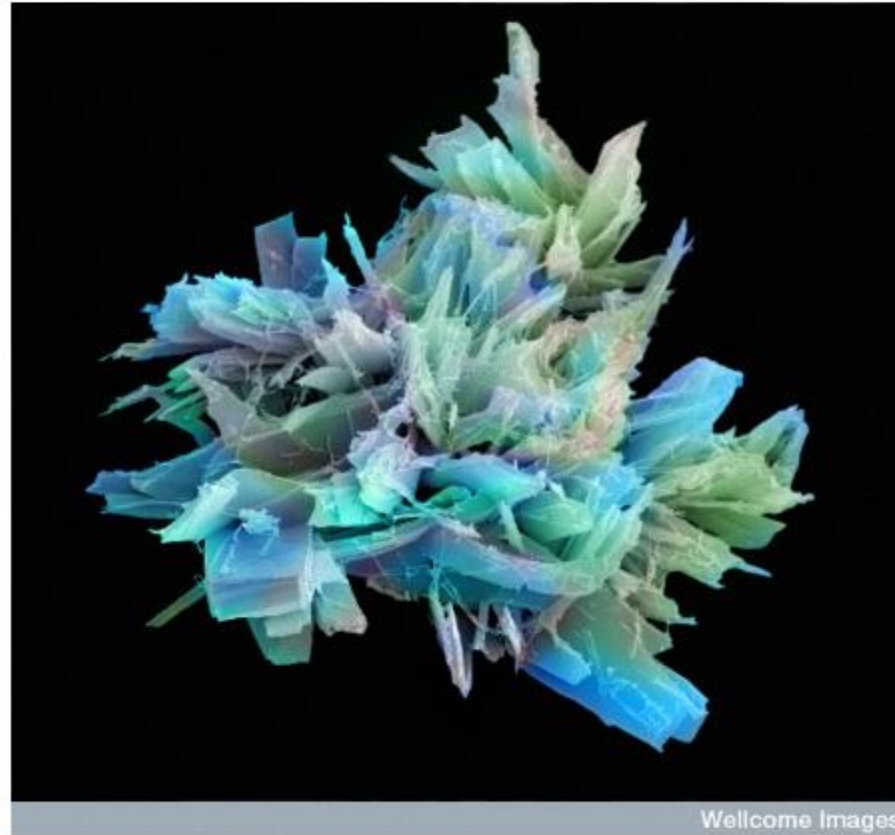
OFF-CAMPUS SERVICES

HELP AND TUTORIALS

HLSC 3P80



## Welcome to the Health Sciences Research Guide



## Health Sciences

HOME

BOOKS & BACKGROUND INFO

ARTICLES

THESES & DISSERTATIONS

WEBSITES

PUBLIC HEALTH

DATA & STATISTICS

NEWS

STREAMING VIDEO

SYSTEMATIC REVIEWS &  
EVIDENCE SYNTHESIS

WRITING AND CITING

OFF-CAMPUS SERVICES

HELP AND TUTORIALS

HLSC 3P80

### Library Guide for HLSC 3P80

A Library course guide to help with resources, videos, tutorials, databases and strategies to be successful completing a rapid review.

This [guide](#) was created by Elizabeth Yates, and updated by Brock Library Teaching & Learning Librarian Ian Gordon.

Reach out if you need further assistance using the Brock Library key contacts [page](#).

Ian Gordon's HLSC 3P80 Fall 2022 [conversation](#) (YouTube, 20:48)

HLSC 3P80 Evidence Synthesis Library Seminar February 15 2023 presentation [slides](#) (PDF)

PRISMA 2020 Word Flow Chart Generator [template](#) (Internet Archives copy)

<https://prisma-statement.org> has been acting up lately.

[zoterobib](#)

[zotero](#)

WordHippo [database](#)

MeSH Headings [database](#) (NLM)

Covidence [database](#)

[Rapid Review Guidebook: Steps for Conducting a Rapid Review](#) (Dobbins, 2017, PDF)

[Systematic Review and Evidence Synthesis Guide](#) (University of Minnesota Libraries)

[How to Search the Literature: The Basics](#) (Evidence Synthesis, McMaster University Health Sciences Library)

[How to Search the Literature: Advanced](#) (Evidence Synthesis, McMaster University Health Sciences Library)





What is evidence synthesis?

# EVIDENCE SYNTHESIS

- Synthesized evidence is considered:

- less biased
- more rigorous
- more generalizable

- Hierarchy of pre-processed evidence

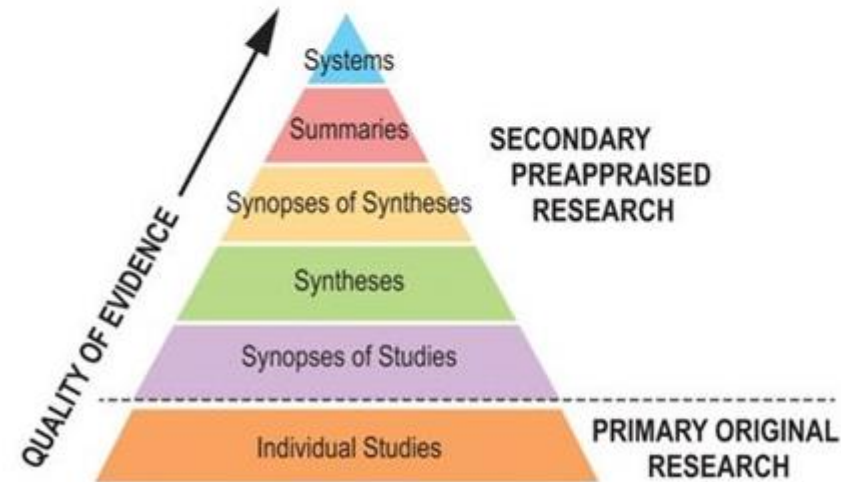


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Image: Duke University Library <https://guides.mclibrary.duke.edu/ebm/home>

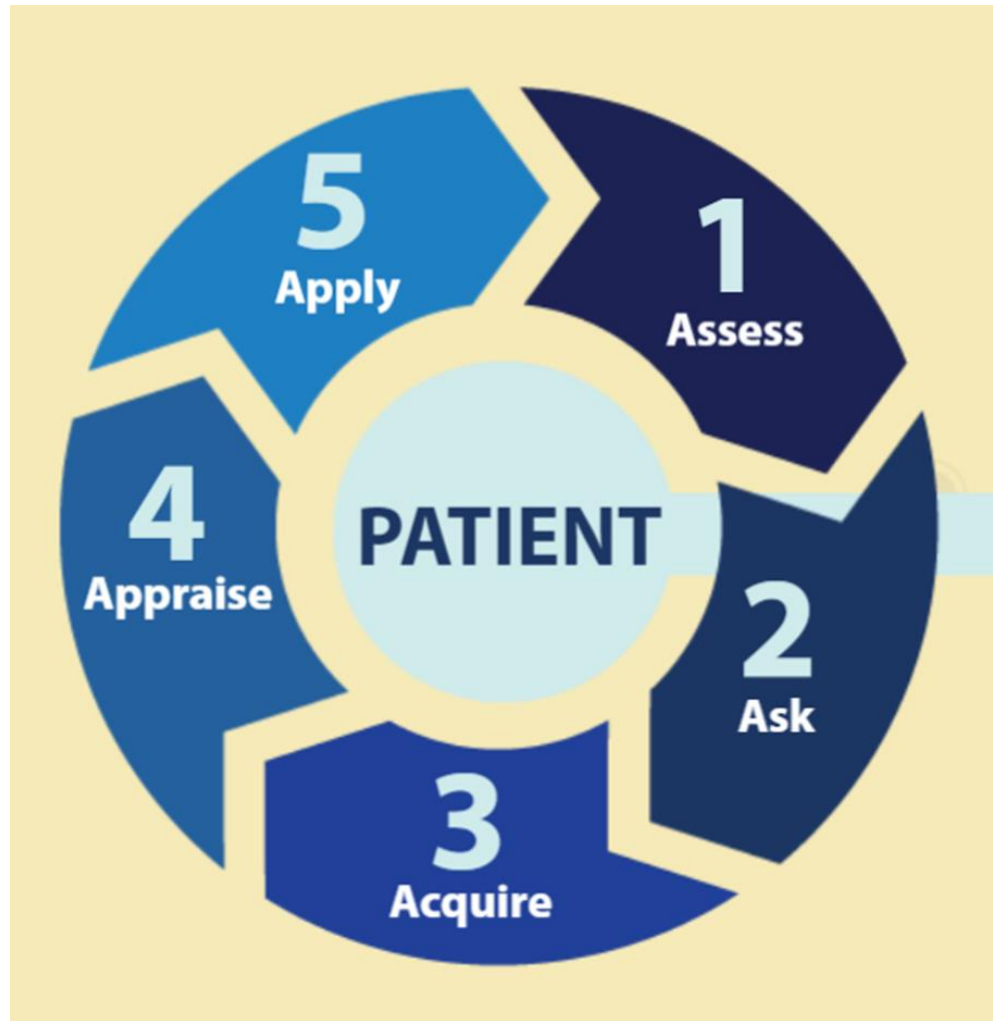
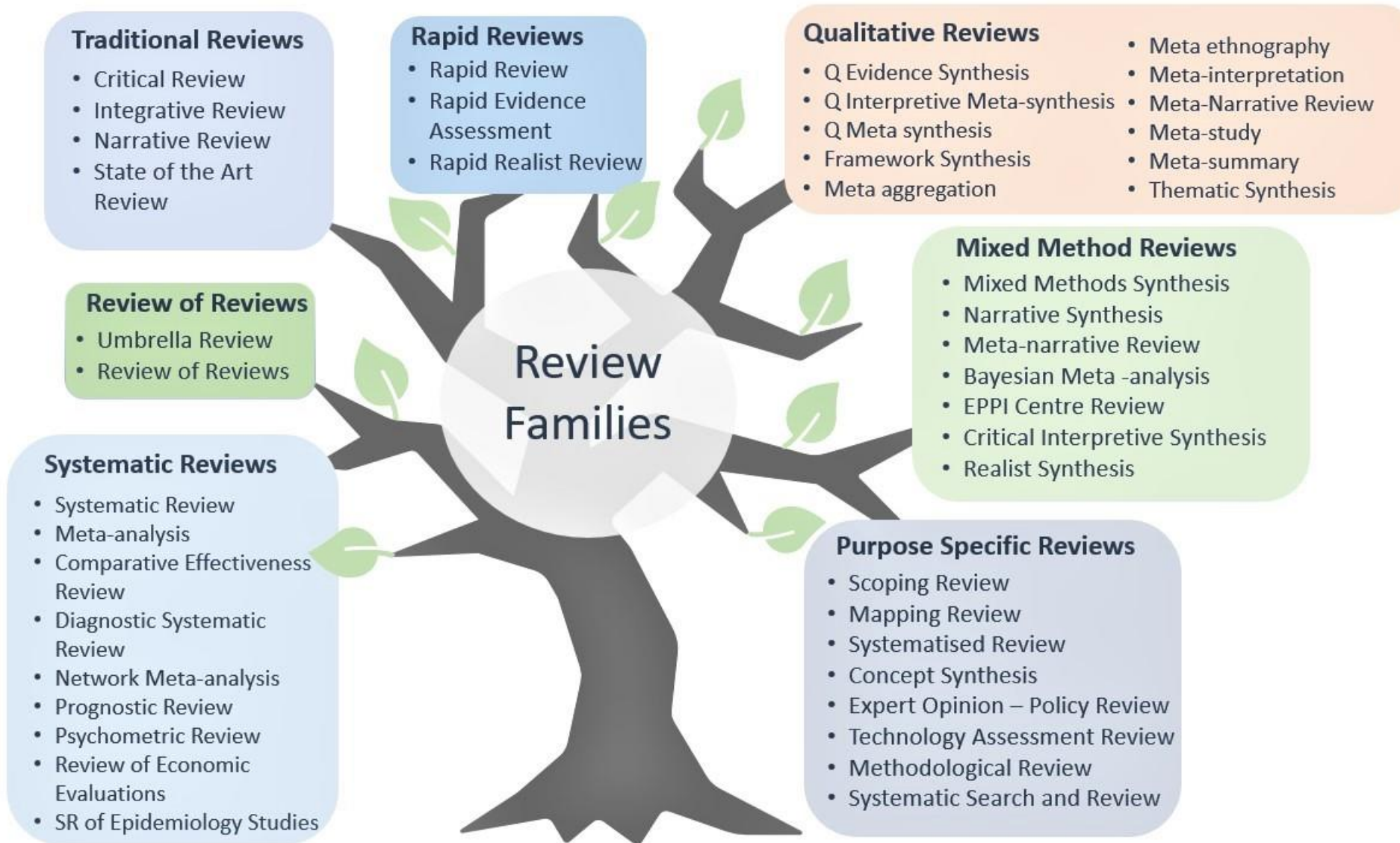


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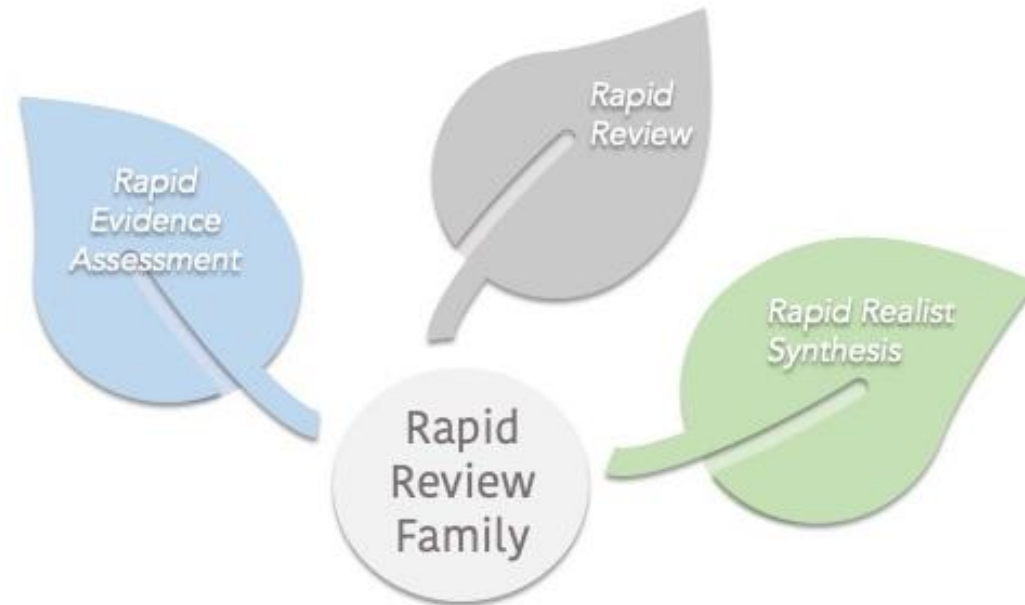
# STEPS IN EVIDENCE SYNTHESIS

Evidence synthesis generally involves these steps:

- Stating the objectives of the research
- Defining eligibility criteria for studies to be included and excluded
- Identifying (all) potentially eligible studies
- Screening for inclusion and exclusion
- Extracting data from the final set of screened studies
- Appraising the final set of studies
- Applying statistical analysis, if applicable
- Preparing a structured report of the research



*Reviews that are grouped within this family due to the abbreviated approach to the typical review methodology processes. This may include the search, appraisal and reporting so that the review is completed in a time-efficient manner to fit within project deadlines. (Moher et al., 2015).*





# WHY ARE THEY MORE RAPID?

**“a type of knowledge synthesis in which components of the systematic review process are simplified or omitted to produce information in a short period of time..”**

May use:

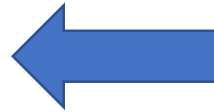
- Very narrow research question
- Less sophisticated search strategies
- Search fewer sources
- Simple, descriptive quality appraisal



Research Question



Rapid Review





Validity

Bias



An example of a rapid review

Virk, F., Waine, J., & Berry, C. (2022). A rapid review of emergency department interventions for children and young people presenting with suicidal ideation. *BJPsych Open*, 8(2), e56. <https://doi.org/10.1192/bjo.2022.21>



**BJPsych Open**

**Article contents**

- Abstract
- Background
- Aims
- Method
- Results
- Conclusions
- Method
- Results
- Discussion
- Data availability
- References

## A rapid review of emergency department interventions for children and young people presenting with suicidal ideation

Published online by Cambridge University Press: **04 March 2022**

Farazi Virk , Julie Waine and Clio Berry 

Show author details ▾

**Article** Figures Supplementary materials eLetters Metrics

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### Abstract

#### Background

Suicidal ideation is an increasingly common presentation to the paediatric emergency department. The presence of suicidal ideation is linked to acute psychiatric hospital admission and increased risk of suicide. The paediatric emergency department plays a critical role in reducing risk of suicide, strengthening protective factors and encouraging patient engagement with ongoing care.

#### Aims

This rapid review aims to synthesise evidence on interventions that can be implemented in the paediatric emergency department for children and adolescents presenting with suicidal ideation.

Virk, F., Waine, J., & Berry, C. (2022). A rapid review of emergency department interventions for children and young people presenting with suicidal ideation. *BJPsych Open*, 8(2), e56. <https://doi.org/10.1192/bjo.2022.21>

## Review

# A rapid review of emergency department interventions for children and young people presenting with suicidal ideation

Farazi Virk, Julie Waine and Clio Berry

### Background

Suicidal ideation is an increasingly common presentation to the paediatric emergency department. The presence of suicidal ideation is linked to acute psychiatric hospital admission and increased risk of suicide. The paediatric emergency department plays a critical role in reducing risk of suicide, strengthening protective factors and encouraging patient engagement with ongoing care.

### Aims

This rapid review aims to synthesise evidence on interventions that can be implemented in the paediatric emergency department for children and adolescents presenting with suicidal ideation.

### Method

Six electronic databases were searched for studies published since January 2010: PubMed, Web of Science, Medline, PsycINFO, CINAHL and Cochrane. Outcomes of interest included suicidal ideation, engagement with out-patient services, incidence of depressive symptoms, hopelessness, family empowerment, hospital admission and feasibility of interventions. The Cochrane risk-of-bias tool was used to evaluate the quality of studies.

### Results

Six studies of paediatric emergency department-initiated family-based ( $n = 4$ ) and motivational interviewing interventions ( $n = 2$ )

were narratively reviewed. The studies were mainly small and of varying quality. The evidence synthesis suggests that both types of intervention, when initiated by the paediatric emergency department, reduce suicidal ideation and improve patient engagement with out-patient services. Family-based interventions also showed a reduction in suicidality and improvement in family empowerment, hopelessness and depressive symptoms.

### Conclusions

Paediatric emergency department-initiated interventions are crucial to reduce suicidal ideation and risk of suicide, and to enhance ongoing engagement with out-patient services. Further research is needed, however, family-based and motivational interviewing interventions could be feasibly and effectively implemented in the paediatric emergency department setting.

### Keywords

Suicide; suicidal ideation; management; emergency department; psychosocial interventions.

### Copyright and usage

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The paediatric emergency department (PED) plays an integral role in ensuring children and adolescents at risk of suicide have timely access to appropriate resources. Suicide rates have increased in adolescents aged 15–19 years from 3.1 to 5.7/100 000 between 2010 and 2019 in the UK.<sup>1</sup> Approximately 13% of 5- to 19-year-olds have at least one mental disorder;<sup>2–3</sup> mental health presentations to a UK emergency care centre have increased threefold compared with 2019, and the most common reason for referral to Child and Adolescent Mental Health Services (CAMHS) in 13- to 17-year-olds was intentional overdose or self-harm.<sup>3</sup> In 2018, there were 204 suicides recorded in England and Wales in young people aged 10–19 years.<sup>4</sup> Suicide denotes 'the act of intentionally ending one's life'.<sup>5</sup> Mental health problems among children and young people appear to be increasing, as does suicidal ideation. Moreover, in early 2020, the COVID-19 pandemic began to place an additional significant burden on child mental health and have a substantial impact on psychosocial development.<sup>6</sup> In Ireland, mental health attendances to the PED initially decreased by 26.8% during the first 4 months of the pandemic; by July and August, mental health presentations increased by 54.4% and 45.5% from September to December compared with 2019 data, highlighting the impact of COVID-19 on child mental health.<sup>7</sup> Although the strongest predictor for suicide remains a previous suicide attempt, a third of adolescents who experience suicidal ideation for the

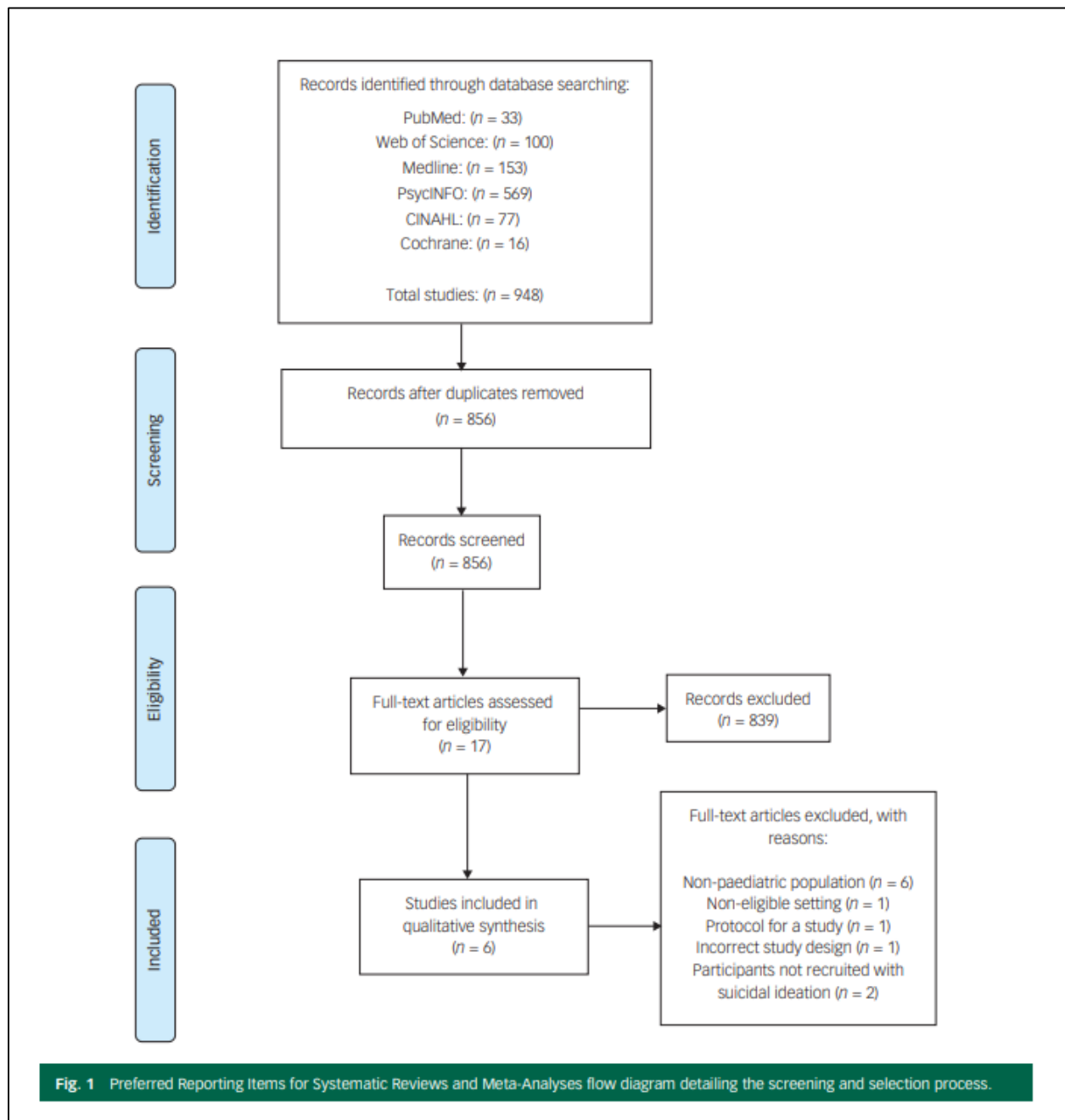
first time go on to attempt suicide.<sup>8,9</sup> Consequently, it is imperative to ensure that interventions offered to children and young people presenting to the PED are beneficial. Furthermore, the risk of a repeated suicide attempt is the highest during the first 6 months after a suicide attempt, which emphasises the importance of providing interventions that have a long-lasting effect, and of the need for robust follow-up post-discharge from the PED.<sup>10,11</sup>

A presentation of suicidal ideation has been considered as the most important sign of short-term suicide risk and warrants an in-depth clinical assessment.<sup>12</sup> Studies have found that talking about suicide does not inadvertently create risk, and may lead to a reduction in distress in individuals who are experiencing suicidal thoughts.<sup>12</sup> However, suicidal intent is difficult to measure, and a proportion of suicides occur as a result of individuals misjudging the risk.<sup>5</sup> Children understand the concept of suicide and death as permanent by 8 years of age;<sup>13</sup> nevertheless, clinicians must sensitively assess suicidal cognitions in children by in the context of rapport and empathy, within an open discussion centred around patient well-being. Worryingly, 25% of patients presenting to the PED who did not declare suicidal thoughts had suicidal ideation,<sup>14</sup> and children and young people who died by suicide did not necessarily express recent suicidal ideation.<sup>15</sup> Unrecognised suicidal ideation may be a result of insufficient time to explore patient well-being or a lack of mental health training for emergency department

Farazi Virk, Julie Waine, Clio Berry. A rapid review of emergency department interventions for children and young people presenting with suicidal ideation. PROSPERO 2021 CRD42021225364 Available from: [https://www.crd.york.ac.uk/prospERO/display\\_record.php?ID=CRD42021225364](https://www.crd.york.ac.uk/prospERO/display_record.php?ID=CRD42021225364)

<b>Condition or domain being studied</b>
Suicidal ideation presentations in children and adolescents to the paediatric emergency department.
<b>Participants/population</b> [1 change]
Inclusion Criteria
- Children and adolescents aged 6-19 years.
- At least 25% patients recruited from PED.
Exclusion Criteria
- Children aged under 6 years
- Adults aged 18 years and over
<b>Intervention(s), exposure(s)</b> [1 change]
Inclusion
- Psychological/Psychosocial/non-pharmacological interventions targeting suicidality.
Exclusion
- Pharmacological interventions.
<b>Comparator(s)/control</b> [1 change]
Inclusion - Any comparator, including TAU.
Exclusion - No comparator
<b>Main outcome(s)</b> [1 change]
- Suicidal ideation, depressive symptoms, hopelessness, family empowerment and/or hospitalisation.
- And/or the feasibility of the intervention.
- And/or outpatient services and follow-up treatment.

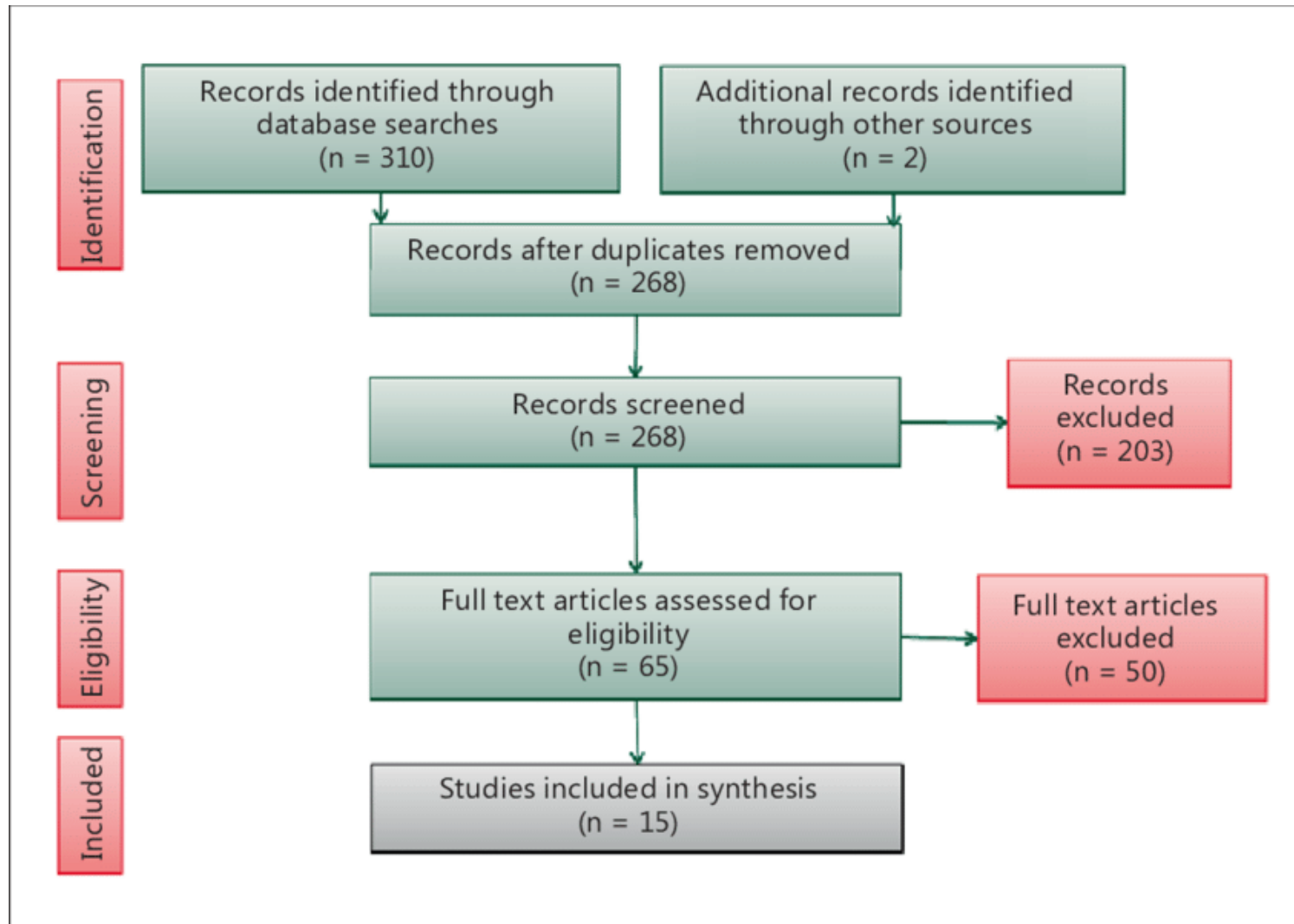
<b>NIHR</b>   National Institute for Health Research	<b>PROSPERO</b> International prospective register of systematic reviews
<a href="#">Print</a>   <a href="#">PDF</a>	
<b>A rapid review of emergency department interventions for children and young people presenting with suicidal ideation</b>	
Farazi Virk, Julie Waine, Clio Berry	
<b>Citation</b>	
Farazi Virk, Julie Waine, Clio Berry. A rapid review of emergency department interventions for children and young people presenting with suicidal ideation. PROSPERO 2021 CRD42021225364 Available from: <a href="https://www.crd.york.ac.uk/prospERO/display_record.php?ID=CRD42021225364">https://www.crd.york.ac.uk/prospERO/display_record.php?ID=CRD42021225364</a>	
<b>Review question</b> [1 change]	
A rapid review of emergency department interventions for children and young people presenting with suicidal ideation	
Population - Children and adolescents aged 6-19 years.	
- At least 25% patients recruited from PED.	
Intervention - Psychological/Psychosocial/non-pharmacological interventions targeting suicidality.	
Comparator - Any comparator, including TAU.	
Outcomes - Suicidal ideation, depressive symptoms, hopelessness, family empowerment and/or hospitalisation.	
- And/or the feasibility of the intervention.	
- And/or outpatient services and follow-up treatment.	
Study Design - Randomised Controlled Trials (RCTs)	
- Full text in the English language	
Setting - Intervention deployed in clinical setting.	
- Any country.	
<b>Searches</b> [1 change]	
A comprehensive search of six databases was undertaken for full-text articles published in a variety of journals. The following databases were analysed: PubMed, Web of Science, MEDLINE, PsycINFO, CINAHL and Cochrane Library. RCTs published in the English Language between January 2010 to December 2020 as a full-text article will be included.	
<b>Types of study to be included</b> [2 changes]	
Randomised controlled trials	
<b>Condition or domain being studied</b>	
Suicidal ideation presentations in children and adolescents to the paediatric emergency department.	

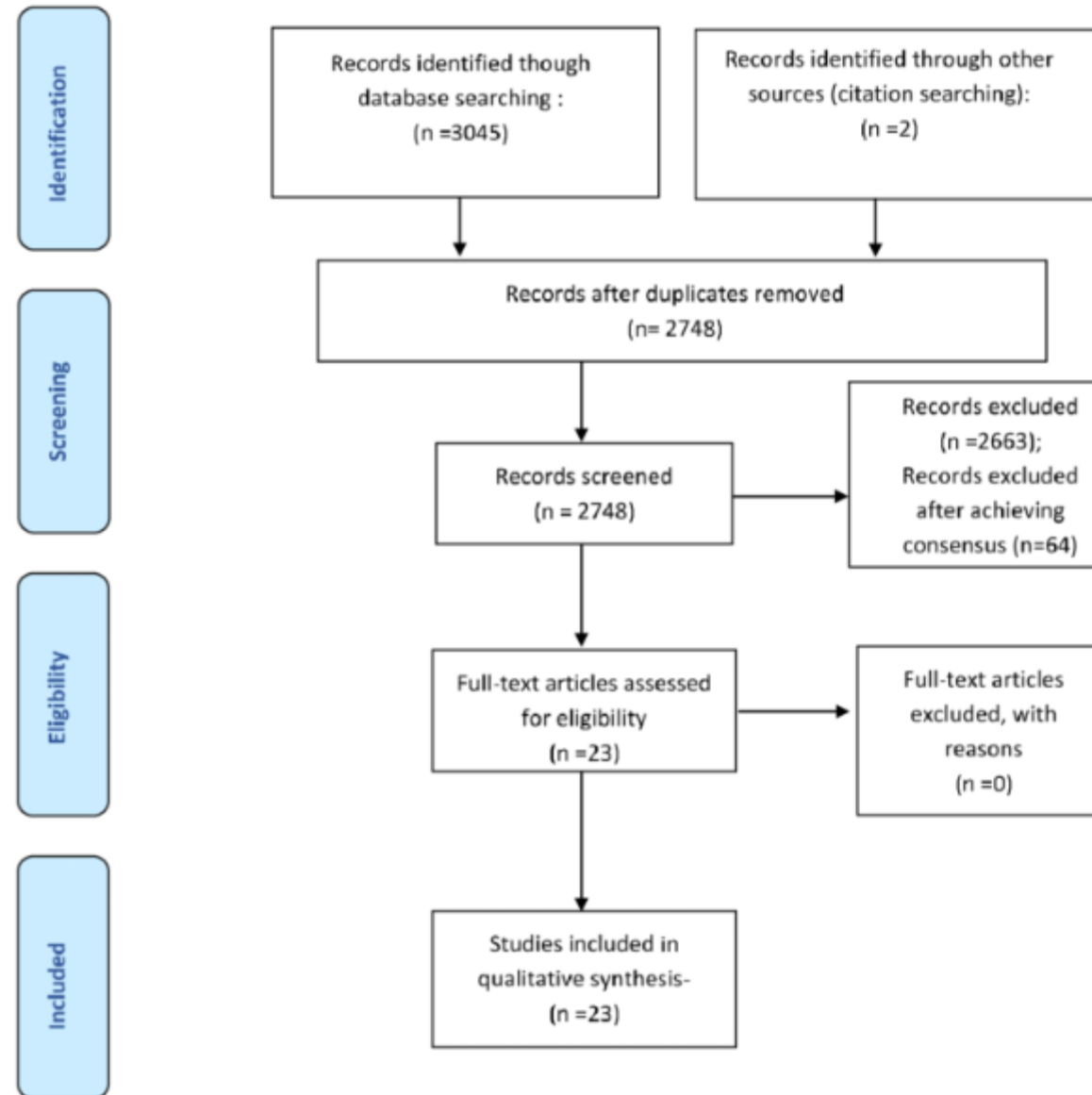




**Fig. 1** Flowchart of study selection







**Table 1** Population, Intervention, Comparison, Outcomes and Study (PICOS) inclusion and exclusion criteria

	Inclusion criteria	Exclusion criteria
Population	Children and adolescents aged 6–19 years At least 25% patients recruited from the paediatric emergency department	
Intervention	Psychological/psychosocial/non-pharmacological interventions targeting suicidality	Pharmacological interventions
Comparator	Any comparator, including treatment as usual	
Outcomes	Suicidal ideation, depressive symptoms, hopelessness, family empowerment and/or hospital admission And/or the feasibility of the intervention And/or out-patient services and follow-up treatment	
Study design	Randomised controlled trials Full text in the English language	Non-randomised controlled trials Non-English language Published before January 2010
Setting	Intervention deployed in clinical setting Any country	Interventions deployed outside clinical settings

**Table 2** Outlines the key characteristics of the included studies

Authors (year), country	Target population	Design	Participants	Intervention(s)	Control condition	Outcomes post-intervention	Outcomes at follow-up	Outcome measure, overall result and follow-up
Asarnow et al (2011), California, USA <sup>53</sup> Click or tap here to enter text.	Inclusion: 'Presenting with suicide attempt and/or suicidal ideation.' Exclusion: 'Acute psychosis/symptoms impeding consent/assessment; no parent/guardian to consent, youth non English speaking, parents/guardians non English or Spanish speaking.' Recruited from: PED	RCT	Sample N = 181, age range 10–18 years, treatment group n = 89, control group n = 92	FISP in emergency department designed to increase motivation for follow-up treatment and safety supplemented by telephone contacts after discharge. Delivered by: FISP clinicians. Clinicians with graduate mental health training received didactic training until certified proficient.	EUC: staff received one training session	Out-patient mental health treatment: FISP patients were significantly more likely than controls to be linked to out-patient treatment (92% v. 76%; odds ratio 6.2; 95% CI 1.8–21.3; P = 0.004) Suicidality: only reported at follow-up Depression: Not reported post-intervention	Out-patient mental health treatment: only reported post-intervention Suicidality: at follow-up, nine youths had attempted suicide (6%), four received the FISP intervention (6%) and five received enhanced usual emergency care (6%). One completed suicide Depression: statistically significant improvements from baseline to follow-up: CES-D total score (t = -8.5, d.f. = 130, P < 0.0001), severe CES-D (odds ratio 0.24, 95% CI 0.14–0.41, P < 0.0001)	Primary outcome: linking patients to out-patient mental health treatment and suicidality Exploratory outcomes: depression Overall: effective in linking youth to follow-up care and no statistically significant effect on suicidality Follow-up: 2 months
Diamond et al (2010), Philadelphia, USA <sup>49</sup> Click or tap here to enter text.	Inclusion: 'Adolescents who scored >31 on the SIQ and above 20 on the BDI-II.' Exclusion: 'Adolescents needing psychiatric hospitalisation, recently discharged from a psychiatric hospital, current psychosis or mental retardation or history of borderline intellectual functioning.' Recruited from: Primary care (75%) and PED (25%)	RCT	Sample N = 66, age range 12–17 years, treatment group n = 35, control group n = 31	ABFT: strengthening parent–adolescent bonds. Therapy starts by discussing what enables adolescents to turn to his/her parent(s) when contemplating suicide. Followed by a session for the adolescent to identify core family conflicts linked to suicide and prepares the adolescent to speak to his or her parent(s) in the next sessions. The next task focused on parental love, empathy and parenting skills. After this families came together to discuss identified problems and practice communication skills. The final task promoted adolescent autonomy while maintaining a family connection Delivered by: Not reported	EUC: a facilitated referral process with ongoing monitoring. Other providers set up initial appointments and encouraged participant attendance	Suicidal ideation: Not reported at post-intervention Depressive symptoms: Not reported at post-intervention	Suicidal ideation: 24 weeks, 82.1% of ABFT participants and 46.2% of EUC participants reported no suicidal ideation in the past week (odds ratio 5.37, 95% CI 1.56–18.49, $\chi^2(1) = 7.66$ , P = 0.006) Depressive symptoms: 24 weeks follow-up, 58.1% of ABFT participants and 38.5% of EUC participants reported non-clinical depression scores (odds ratio 2.21, 95% CI 0.76–6.42, $\chi^2(1) = 2.17$ , P = 0.14)	Primary outcomes: suicidal ideation and depressive symptoms Overall: ABFT showed a slightly higher rate of improvement for suicidal ideation. The intervention group showed significant improvements in depressive symptoms. The number of cases of suicidal ideation and repetition of self-harm was similar for both groups at the post-intervention period Follow-up: 6 months (Continued)

**Table 1** Characteristics of included studies

Study ID	Country	Study design	Study quality	Duration	Population age (years)	Sample size (females)	PHE	Outcome	Mechanisms underlying the effect of PHE on outcomes
Rashid and Michaud [36]	Bangladesh	Qualitative design using face-to-face in-depth interviews and informal discussions	Some concerns	1998	15–19	9	Flood	Sexual and reproductive health (privacy to bathe, use latrine, and maintain good menstrual hygiene)	Limited access to health services Disruption of social network Sharing a private space, like toilets and bathrooms, with men
Zulaka et al. [37]	Kenya	Panel data self-administered survey	High	May 2018 – March 2021	13–17	910	COVID-19	Sexual and reproductive health (pregnancy and sexual debut)	Closure of schools Disruption in schooling due to lockdown Reduction in household income
Temple et al. [38]	The United States	Cross-sectional face-to-face risk behaviour survey	Low	March 2009	14–18	584 447 (final sample)	Hurricane	Physical and sexual violence by a boyfriend	Intensity of exposure to traumatic stressor Substance abuse
Sloand et al. [39]	Haiti	Cross-sectional audio computer-based interviews	Some concerns	2011–2013	12–17	78	Earthquake	Dating violence by boyfriend or ex-boyfriend and domestic violence by a family member	Low levels of education Young age Limited access to mental health services Social norms around intimate partner violence (IPV)
Cerna-Turoff et al. [40]	Haiti	Cross-sectional face-to-face household survey	High	2012	13–17	1,457	Earthquake	Physical, emotional, and sexual violence by a family or non-family member	Not reported
Epstein et al. [41]	19 Sub-Saharan African countries	Repeated face-to-face cross-sectional survey	High	2011–2018	15–19	5,316	Drought	Physical, emotional, and sexual violence by intimate partner	Young age Lower social standing and inexperience with relationships Financial strain and food insecurity Stress and poor mental health conditions Disempowerment, unemployment, and economic dependence on partner



## Outcomes of interventions

### Suicidal ideation

Five studies examined the impact of interventions on suicidal ideation, and outcome measures varied across studies.<sup>48,49,51–53</sup> One study measured suicidal ideation with the Harkavy–Asnis Suicide Scale, to assess active and passive suicidal ideation.<sup>53</sup> Three studies used the Suicidal Ideation Questionnaire-Junior to assess suicidal ideation.<sup>48,51,52</sup> One study measured change over time in adolescent suicidality (Reasons for Living Inventory for Adolescents; RFL-A).<sup>48</sup> Asarnow et al evaluated suicidality as an exploratory outcome; results illustrated no statistically significant intervention effects on suicidality.<sup>53</sup> In the motivational interviewing intervention by Grupp-Phelan et al, there was a significant decrease in suicidal ideation across groups.<sup>52</sup> Diamond et al found a slightly higher rate of improvement owing to a rapid reduction in suicidal ideation in the ABFT intervention group compared with the control group.<sup>49</sup> At the end of the follow-up period, 82.1% of participants receiving the intervention reported no suicidal ideation in the past week compared with 46.2% of enhanced usual care (EUC) participants.<sup>49</sup> Over the 6-month follow-up period, four out of 35 intervention group participants (11.4%) had made a suicide attempt, compared with seven out of 33 (21.2%) EUC participants.<sup>49</sup> King et al reported a significant decrease in time for suicidal ideation over the study period.<sup>51</sup> Wharff et al reported increases in the mean RFL-A total scores over the study period; however, there were no significant differences between the groups.<sup>48</sup> This intervention illustrated that participants had lower levels of suicidality over time at 1-month follow-up compared with their baseline assessment.<sup>48</sup>

### Depressive symptoms and hopelessness

Three studies explored the impact of the intervention on depressive symptoms.<sup>49,51,52</sup> Diamond et al measured depression with the self-report Beck Depression Inventory, and results showed significant effects supported by large effect sizes.<sup>49</sup> After treatment, at 6-month follow-up, 54.8% of ABFT participants and 31.0% of EUC participants had non-clinical depression scores.<sup>49</sup> The Reynold

### Engagement with out-patient services

Two studies investigated the impact of interventions on engagement with out-patient services and treatment initiation.<sup>52,53</sup> Grupp-Phelan et al explored treatment initiation and attendance. Exploratory outcomes showed no significant difference between the STAT-ED intervention and EUC in the rate of mental health appointments at 2-month follow-up.<sup>52</sup> However, by 6 months, follow-up participants in the STAT-ED group were more likely to initiate mental health treatment and the overall rate of mental health appointments were significantly higher in the STAT-ED group compared with EUC.<sup>52</sup> Asarnow et al intervention included a telephone contact within 48 h of discharge from the PED, to motivate and support out-patient treatment.<sup>53</sup> More FISP participants were likely to receive out-patient treatment and had significantly more visits compared with the control.<sup>53</sup>

### Family empowerment

In one study, family empowerment was measured as an outcome.<sup>48</sup> Scores were obtained with a 34-item self-report Family Empowerment Scale (FES) that measures the level of empowerment of parents of a child with emotional difficulties.<sup>48</sup> The FES questionnaire is completed by parents to assesses family, child and parental involvement within the community.<sup>55</sup> Parents answer questions such as 'I feel I am a good parent', 'I make sure I stay in regular contact with professionals who are providing my child services' and 'I have ideas about the ideal service system for children'.<sup>55</sup> The scoring scale is rated 1–5; 1 equates to 'never' and 5 to 'very often'.<sup>55</sup> Wharff et al reported higher scores for family empowerment during the study.<sup>48</sup> At the 1-month follow-up, there were statistically significant increases in the FES score.<sup>48</sup>

### Hospital admission

One study evaluated the impact of the intervention on in-patient psychiatric hospital stay.<sup>48</sup> The FBCI demonstrated that participants randomised to the intervention were significantly less likely to be admitted to hospital compared with treatment as usual.<sup>48</sup> During the study, 68% of treatment-as-usual participants were admitted to hospital, compared with only 38% of FBCI participants.<sup>48</sup>

## Discussion

This rapid review aimed to investigate interventions used in the PED setting for children and adolescents presenting with suicidal ideation. Six studies met the review inclusion criteria. All studies were initiated in the PED. The studies provided evidence for the impact of these interventions on suicidal ideation.<sup>48–53</sup> Studies also outlined positive effects of interventions on patient engagement with out-patient follow-up treatment, depressive symptoms, hopelessness, family empowerment, hospital admission and intervention feasibility.<sup>48–53</sup> To our knowledge, our study is the most recent and first rapid review to focus on a broad range of outcome measures to support PED care for young people presenting with suicidal ideation, as well as to identify areas requiring further research.

Two potential interventions were identified in this review; four studies involved family-based interventions and two studies comprised motivational interviewing interventions.<sup>48–53</sup> Overall, findings suggest that family-based interventions are associated with a reduction in suicidal ideation, whereas evidence for the benefit of motivational interviewing is more equivocal. Overall, there is a lack of high-quality evidence because several limitations within the included studies, and therefore the conclusions should be drawn with caution.

Included studies that investigated the effects of family-based interventions on suicidal ideation consisted of dedicated sessions with families and patients in the PED to strengthen family bonds during a time of crisis. This is in keeping with a clinical review that highlighted early involvement of the family, formulation of

## References

- 1 Office for National Statistics. *Suicides in England and Wales*. Office for National Statistics, 2021 (<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables>).
- 2 The Lancet. Child mental health services in England: a continuing crisis. *Lancet* 2020; **395**(10222): 389.
- 3 McCall B. *Threefold Rise in Mental Health Referrals from Paediatric Emergency during COVID-19*. Medscape, 2021 (<https://www.medscape.com/viewarticle/953755>).
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So why is evidence synthesis so important to health sciences research?

**RAPID REVIEW PAPER**

The final paper is to be a rapid review style, which is a systematic-type of literature review following the PRISMA guidelines.

**Format Guidelines:** Include a cover page with your name, student number, course code, and the date and title of the assignment (Create a title specific to your topic and include “rapid review”). Be professional (avoid fancy graphics/font/etc.). Papers should use double-spaced, include page numbers, use 12pt Times New Roman font, and with 2 to 2.54 cm margins on all sides. Paragraphs and section headers must be used to organize the paper. References must follow APA format guidelines (both in-text citations and reference list). Figure and table titles are required. Marks will be deducted if format guidelines are not followed.

**Style Guidelines:** In addition to above format guidelines and the PRISMA guidelines (below), students are graded based on writing style. Proper spelling, grammar, punctuation, formal and scholarly language (e.g., no slang or contractions), and full sentences (no bullet points) are expected. Writing needs to be clear and understandable, and ideas should be organized in a logical manner.

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**What are the PRISMA Guidelines?**

“PRISMA” refers to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). PRISMA is an evidence-based minimum set of items to help authors improve the reporting of systematic reviews and meta-analyses. PRISMA focuses on the reporting of reviews evaluating randomized trials, but can also be used as a basis for reporting systematic reviews of other types of research. The guidelines help to ensure transparent and complete reporting of this type of research and provide a structure and guide for authors (such as you!).

The checklist includes 27 items pertaining to the content of a systematic review and meta-analysis, which include the title, abstract, methods, results, discussion, and funding. We will be adapting the checklist for our purposes, as you are to write a Rapid Review (which is a systematic-type of review but not a ‘Systematic Review’, in that it uses a transparent methodology but is streamlined, in comparison) and you are not required to do a Meta-analyses.

**CONTENT:** All indicated components of the PRISMA Checklist (**See Attached**) must be included and are worth the corresponding mark indicated. All papers must include a results table and flow diagram (as per PRISMA guidelines). Crossed-out sections of the PRISMA guidelines are not required for this course. Notes (in blue) have been added to the standardized checklist by the instructor in order to help clarify the guidelines and marking criteria.

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## PRISMA 2009 Checklist

Section/topic	#	Checklist Item	Pg #
<b>TITLE (+ Format/Style Guidelines [as per above] /10)</b>			
Title	1	Identify the report as a systematic review, meta-analysis, or both. – Your paper is to be a Rapid Review. Create a title specific to your paper (be creative!) and include in the title that it is a Rapid Review.	
<b>ABSTRACT /10</b>			
Structured summary	2	Provide a structured summary including, <b>as applicable</b> : background; objectives; data sources; study eligibility criteria, participants, and interventions ( <b>may not apply</b> ); study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; <del>systematic review registration number.</del> A 'structured summary' means an Abstract with subtitles (e.g., Background, Objectives, Methods, Results, Conclusions)	
<b>INTRODUCTION /10</b>			
Rationale	3	Describe the rationale for the review in the context of what is already known. (e.g., why is the review needed for your research question? Why is the topic important? Note: you can draw on sources other than articles included in your review for introduction material, if needed [they must still be appropriate sources and referenced appropriately]) You likely have some of this component from your research proposal.	
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions (or exposure, if no intervention), comparisons, outcomes, and study design (PICOS). (i.e., this part is to conduct a rapid review of the literature on your research question – state your research question)	
<b>METHODS /30</b> Methods will be outlining <b>how</b> you will do or did the Review.			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number. <b>Not applicable.</b>	
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale for the criteria used. What types of studies are you going to include or not include?	
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, <del>contact with study authors to identify additional studies</del> ) in the search and date last searched. What are you searching and what was the last date that you searched these sources? (ie what databases? Hand searching of reference lists? etc)	
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated. (i.e., indicate your search string)	
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis). (ie how did you screen studies that resulted from the search to determine which met your eligibility criteria and to come to the ones that are included in your review?)	





## PRISMA 2009 Checklist

Section/topic	#	Checklist Item	pg #
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators. (this component would typically have 2 or more individuals independently searching and sometime includes contacting investigators – yours will not, so it's fairly simple)	
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made. (i.e., what results, variables, and/or study characteristics are you pulling from the articles to report? [eg in your table])	
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis. (i.e. how will you assess the risk of bias in the studies? consider biases related to study design, sample/recruitment procedures, generalizability of sample, group assignment [randomization, blinding], measurement biases, confounding, funding, length of follow-up, etc.)	
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., $I^2$ ) for each meta-analysis.	
Risk of bias <b>across studies</b>	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies, language bias, etc.).	
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	
<b>RESULTS /30</b> *Must include flow diagram and results summary table (NOTE: report results in the table and diagram <b>AND</b> describe them in the written paper). Results are now what you found from your process – your search results, the characteristics of the studies that you included in your review, the results of these studies in answer to your research question, risk of bias in those studies, and risk of bias across studies.			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a <b>flow diagram</b> . (Results of your search – how many results, how many screened, how many excluded and way, etc. You must include a flow diagram, and outline this in your written discussion).	
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations. (ie what do the studies look like that you included in the review? Include Table AND describe in writing)	
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12). (assess each study for risk of bias – see item 12 methods for examples to consider; describe strengths/limitations of <b>individual</b> studies and commonalities in these individual study risk of biases across them)	
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) <b>effect estimates and confidence intervals</b> , ideally with a forest plot. (ie what did the studies find in answer to your research question?)	
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	





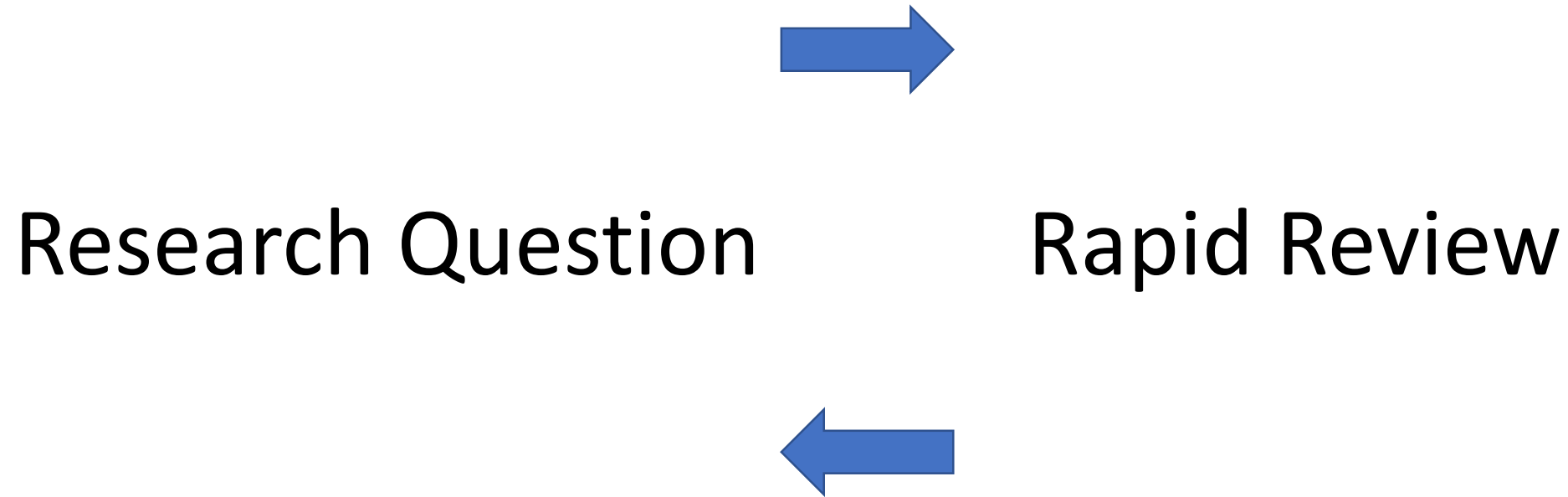


## PRISMA 2009 Checklist

Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15 for examples; why might the results of your group of articles be biased? Are certainly results more likely to be included?)	
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta regression (see Item 16)).	
<b>DISCUSSION /15</b> (e.g., answer to your research question; overall main conclusions and limitations or gaps identified in research reviewed; next steps/future research; limitations of your rapid review)			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers). (overall – what did your rapid review find? What do these studies say in answer to your research question? And what is the strength of this evidence available? What is the relevance – ie what do these results mean to those who could use this evidence?)	
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias). (i.e., limitations overall of the studies that you reviewed, AND potential limitations of your rapid review – think about if/how our rapid review might have missed key evidence and why? Think about what makes a rapid review 'rapid' relative to a Systematic Review?)	
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research. (sum up what the evidence says and means; what are implications for future research based on limitations identified in the research)	
<b>FUNDING</b>			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

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What is your research question?



Has your research question been analyzed using evidence synthesis frameworks or as part of a rapid review protocol?

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#6	...	>	Search: <b>suicide</b> Filters: <b>Meta-Analysis, Review, Systematic Review</b>	12,918	10:48:13
#5	...	>	Search: <b>suicide</b> Filters: <b>Review, Systematic Review</b>	12,569	10:48:08
#4	...	>	Search: <b>suicide</b> Filters: <b>Review</b>	11,621	10:48:03
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Apr 3 2022 | Oct 2020 (Early Access) | [ARCHIVES OF SUICIDE RESEARCH](#) 26 (2) , pp.465-480

Objective While suicide prevention interventions should be informed by lived experience, there are no reviews examining involvement of lived experience (LE) thus far. This rapid review aimed to synthesize available studies using LE of suicidality to guide the development of suicide prevention interventions. Method A rapid review following PRIS ... [Show more](#)

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# A rapid review of emergency department interventions for children and young people presenting with suicidal ideation

By: Virk, F (Virk, Farazi) [1] ; Waine, J (Waine, Julie) [2] ; Berry, C (Berry, Clio) [1]

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Volume: 8 Issue: 2

Article Number: e56; PII S2056472422000217

DOI: 10.1192/bjo.2022.21

Published: MAR 4 2022

Indexed: 2022-03-21

Document Type: Review

## Abstract

Background Suicidal ideation is an increasingly common presentation to the paediatric emergency department. The presence of suicidal ideation is linked to acute psychiatric hospital admission and increased risk of suicide. The paediatric emergency department plays a critical role in reducing risk of suicide, strengthening protective factors and encouraging patient engagement with ongoing care. Aims This rapid review aims to synthesise evidence on interventions that can be implemented in the paediatric emergency department for children and adolescents presenting with suicidal ideation. Method Six electronic databases were searched for studies published since January 2010: PubMed, Web of Science, Medline, PsycINFO, CINAHL and Cochrane. Outcomes of interest included suicidal ideation, engagement with out-patient services, incidence of depressive symptoms, hopelessness, family empowerment, hospital admission and feasibility of interventions. The Cochrane risk-of-bias tool was used to evaluate the quality of studies. Results Six studies of paediatric emergency department-initiated family-based (n = 4) and motivational interviewing interventions (n = 2) were narratively reviewed. The studies were mainly small and of varying quality. The evidence synthesis suggests that both types of intervention, when initiated by the paediatric emergency department, reduce suicidal ideation and improve patient engagement with out-patient services. Family-based interventions also showed a reduction in suicidality and improvement in family empowerment, hopelessness and depressive symptoms. Conclusions Paediatric emergency department-initiated interventions are crucial to reduce suicidal ideation and risk of suicide, and to enhance ongoing engagement with out-patient services. Further research is needed; however, family-based and motivational interviewing interventions could be feasibly and effectively implemented in the paediatric emergency department setting.

## Keywords

Author Keywords: Suicide; suicidal ideation; management; emergency department; psychosocial interventions

Keywords Plus: MENTAL-HEALTH; SELF-HARM; YOUTH SUICIDE; ADOLESCENTS; PREVENTION; RISK; PREVALENCE; BEHAVIORS; TIME; CARE

Review

# A rapid review of emergency department interventions for children and young people presenting with suicidal ideation

Farazi Virk, Julie Waine and Clio Berry

## Background

Suicidal ideation is an increasingly common presentation to the paediatric emergency department. The presence of suicidal ideation is linked to acute psychiatric hospital admission and increased risk of suicide. The paediatric emergency department plays a critical role in reducing risk of suicide, strengthening protective factors and encouraging patient engagement with ongoing care.

## Aims

This rapid review aims to synthesise evidence on interventions that can be implemented in the paediatric emergency department for children and adolescents presenting with suicidal ideation.

## Method

Six electronic databases were searched for studies published since January 2010: PubMed, Web of Science, Medline, PsycINFO, CINAHL and Cochrane. Outcomes of interest included suicidal ideation, engagement with out-patient services, incidence of depressive symptoms, hopelessness, family empowerment, hospital admission and feasibility of interventions. The Cochrane risk-of-bias tool was used to evaluate the quality of studies.

## Results

Six studies of paediatric emergency department-initiated family-based ( $n = 4$ ) and motivational interviewing interventions ( $n = 2$ )

were narratively reviewed. The studies were mainly small and of varying quality. The evidence synthesis suggests that both types of intervention, when initiated by the paediatric emergency department, reduce suicidal ideation and improve patient engagement with out-patient services. Family-based interventions also showed a reduction in suicidality and improvement in family empowerment, hopelessness and depressive symptoms.

## Conclusions

Paediatric emergency department-initiated interventions are crucial to reduce suicidal ideation and risk of suicide, and to enhance ongoing engagement with out-patient services. Further research is needed; however, family-based and motivational interviewing interventions could be feasibly and effectively implemented in the paediatric emergency department setting.

## Keywords

Suicide; suicidal ideation; management; emergency department; psychosocial interventions.

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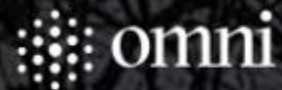
The paediatric emergency department (PED) plays an integral role in ensuring children and adolescents at risk of suicide have timely access to appropriate resources. Suicide rates have increased in adolescents aged 15–19 years from 3.1 to 5.7/100 000 between 2010 and 2019 in the UK.<sup>1</sup> Approximately 13% of 5- to 19-year-olds have at least one mental disorder;<sup>2,3</sup> mental health presentations to a UK emergency care centre have increased threefold compared with 2019, and the most common reason for referral to Child and Adolescent Mental Health Services (CAMHS) in 13- to 17-year-olds was intentional overdose or self-harm.<sup>4</sup> In 2018, there were 204 suicides recorded in England and Wales in young people aged 10–19 years.<sup>4</sup> Suicide denotes ‘the act of intentionally ending one’s life’.<sup>5</sup> Mental health problems among children and young people appear to be increasing, as does suicidal ideation. Moreover, in early 2020, the COVID-19 pandemic began to place an additional significant burden on child mental health and have a substantial impact on psychosocial development.<sup>6</sup> In Ireland, mental health attendances to the PED initially decreased by 26.8% during the first 4 months of the pandemic; by July and August, mental health presentations increased by 54.4% and 45.5% from September to December compared with 2019 data, highlighting the impact of COVID-19 on child mental health.<sup>7</sup> Although the strongest predictor for suicide remains a previous suicide attempt, a third of adolescents who experience suicidal ideation for the

first time go on to attempt suicide.<sup>8,9</sup> Consequently, it is imperative to ensure that interventions offered to children and young people presenting to the PED are beneficial. Furthermore, the risk of a repeated suicide attempt is the highest during the first 6 months after a suicide attempt, which emphasises the importance of providing interventions that have a long-lasting effect, and of the need for robust follow-up post-discharge from the PED.<sup>10,11</sup>

A presentation of suicidal ideation has been considered as the most important sign of short-term suicide risk and warrants an in-depth clinical assessment.<sup>5</sup> Studies have found that talking about suicide does not inadvertently create risk, and may lead to a reduction in distress in individuals who are experiencing suicidal thoughts.<sup>12</sup> However, suicidal intent is difficult to measure, and a proportion of suicides occur as a result of individuals misjudging the risk.<sup>5</sup> Children understand the concept of suicide and death as permanent by 8 years of age;<sup>13</sup> nevertheless, clinicians must sensitively assess suicidal cognitions in children by in the context of rapport and empathy, within an open discussion centred around patient well-being. Worryingly, 25% of patients presenting to the PED who did not declare suicidal thoughts had suicidal ideation,<sup>14</sup> and children and young people who died by suicide did not necessarily express recent suicidal ideation.<sup>15</sup> Unrecognised suicidal ideation may be a result of insufficient time to explore patient well-being or a lack of mental health training for emergency department

Virk, F., Waine, J., & Berry, C. (2022). A rapid review of emergency department interventions for children and young people presenting with suicidal ideation. *BJPsych Open*, 8(2), e56. <https://doi.org/10.1192/bjo.2022.21>





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Journal of affective disorders, 2012, Vol.150 (1), p.123-129

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SD Mayes, AA Gorman, J Hillwig-Garcia... - Research in autism ..., 2013 - Elsevier  
... The majority of **children** (71%) who had all four ... half of **children** with these problems had **suicide ideation** or attempts. All **children** with autism should be screened for **suicide ideation** or ...  
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**Long-term associations of childhood **suicide ideation****  
CM Herba, RF Ferdinand, FC VERHULST - ... American Academy of Child ..., 2007 - Elsevier  
... with **children** without **suicide ideation**, **suicide ideation** in ... A **child** was identified as having **suicide ideation** in the ... T1 and if they met criteria for **suicide ideation** before their 12th birthday (...  
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**Depression and **suicide ideation** in late adolescence and early adulthood are an outcome of **child** hunger**  
L McIntyre, JVA Williams, DH Lavorato... - Journal of affective ..., 2013 - Elsevier  
... of **child**/youth hunger is an independent risk factor for subsequent depression/**suicide ideation** during ... In examining covariates that are predictive of depression/**suicide ideation** in late ...  
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**Hospitalization for **suicide ideation** or attempt: 2008–2015**  
G Plemmons, M Hall, S Douplik, J Gay, C Brown... - ..., 2018 - publications.aap.org  
... attempts and ideation in **children** seeking care at **children's** hospitals, ... **Suicide ideation** (SI) and suicide attempts (SAs) are ... sources for **children** and adolescents directed to **children's** ...  
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**[HTML] **Child** abuse and the prevalence of suicide attempts among those reporting **suicide ideation****  
MS Martin, J Dykxhoorn, TO Affifi, I Colman - Social psychiatry and ..., 2016 - Springer  
... Victims of **child** abuse may be at increased risk of acting on **suicide ideation**, although this has ... attempts associated with **child** abuse among individuals who reported **suicide ideation**. ...  
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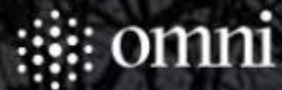
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What scholarly databases are you familiar with when searching for evidence information?



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Omni, Google Scholar, Cochrane, AgeLine, ProQuest Sociology Collection, Education Source, ~~Scopus~~, Semantic Scholar, BASE, Dimensions... other sources

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## Evidence Synthesis Library Seminar Rapid Review Databases

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Cochrane, ProQuest Sociology Collection, Education Source, other sources

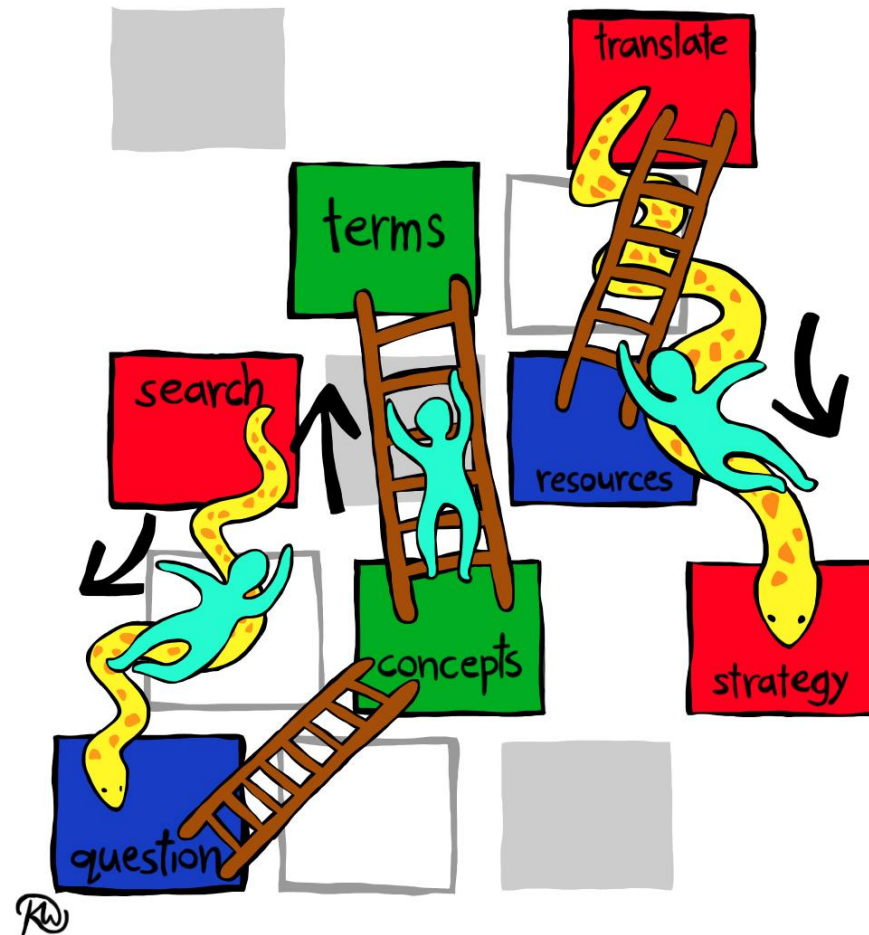
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Is ADHD associated with increased risk of obesity in children?

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Searching is a non-linear and potentially iterative process.



# Evidence-based scholarly database search strategies

# Is ADHD associated with increased risk of obesity in children?

Evidence-based search question frameworks:

PICO: Population/problem, Intervention/exposure, Comparison, and Outcome

SPICE: Setting, Perspective, Interest, Comparison, Evaluation

Concepts: Main search concepts

# Is ADHD associated with increased risk of obesity in children?

Evidence-based search question frameworks:

PICO: Population/problem, Intervention/exposure, Comparison, and Outcome

P: (Who is the question focused on?)

I: (What behavior or variable is being studied?)

C: (How might I evaluate this issue with a broader context?)

O: (What in relation to this issue do I want to examine?)

# Is ADHD associated with increased risk of obesity in children?

Evidence-based search question frameworks:

SPICE: Setting, Perspective, Interest/Intervention/Exposure, Comparison, Evaluation

S: (Setting is the context for the question)

P: (Perspective is the users, potential users, or stakeholders of the service...)

I: (Intervention is the action taken for the users, potential users, or stakeholders...)

C: (Comparison is the alternative actions or outcomes...)

E: (Evaluation is the result of measurement that will determine the success of the intervention...)

# Is ADHD associated with increased risk of obesity in children?

Evidence-based search question frameworks:

Main Search Concepts

What are the main search concepts/populations/issue of interest for your rapid review?

Is ADHD associated with increased risk of obesity in children?

Evidence-based search question frameworks:

Main Search Concepts

What are the main search concepts/populations/issue of interest for your rapid review?

# Is ADHD associated with increased risk of obesity in children?

Evidence-based search question frameworks:

Main Search Concepts

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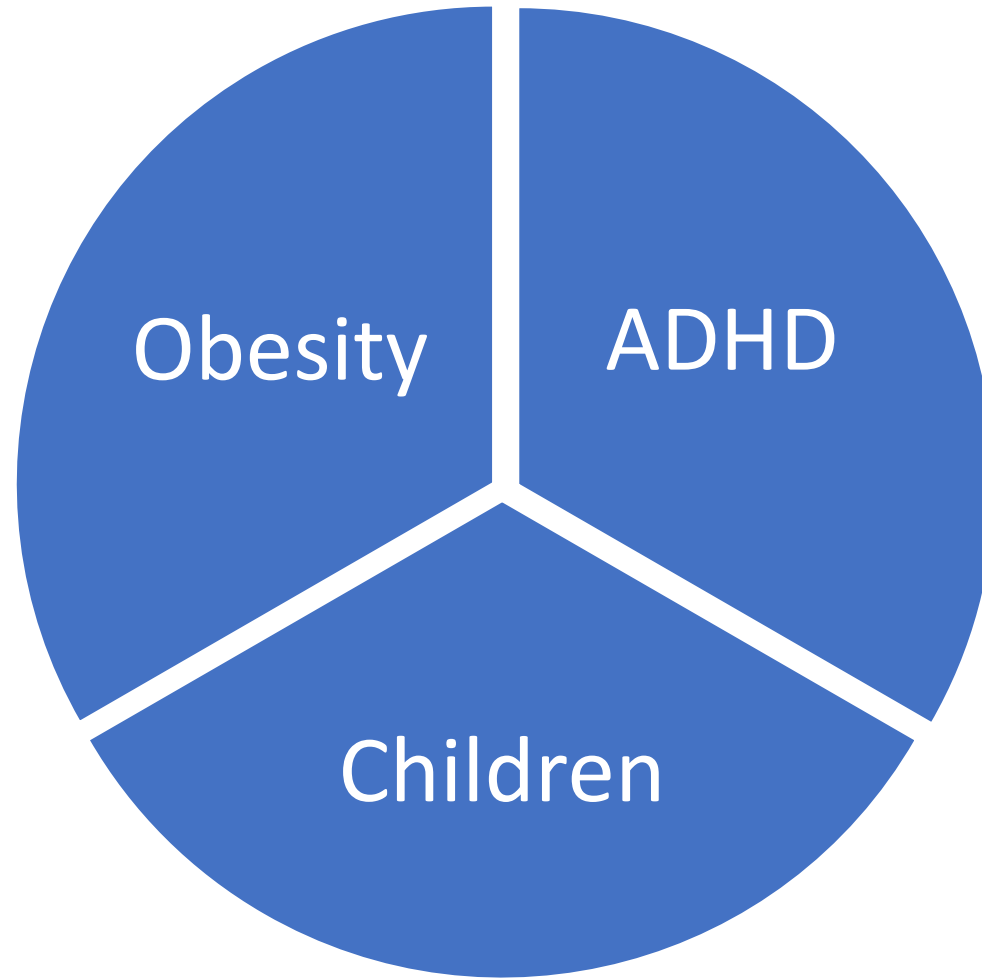
Obesity

ADHD

Children



Is ADHD associated with increased risk of obesity in children?



Currency of information  
Language  
Discipline  
Format

# What is another word for obesity?



wordhippo

Need *synonyms for obesity*? Here's a list of *similar words* from our *thesaurus* that you can use instead.


## Noun

The state of being extremely overweight

fatness corpulence plumpness chubbiness fleshiness portliness  
rotundity grossness embonpoint fat weight pudginess  
pursiness corpulency stoutness adiposity heaviness fattiness  
flab podginess tubbiness bulk beef flabbiness chunkiness  
paunchiness bulkiness size largeness overweight avoirdupois  
rotundness overweightness weight problem roundness porkiness  
meatiness paunch blubber beefiness heftiness beer belly  
bloatedness flesh dumpiness excessive weight pot belly  
beer gut burliness sphericalness fubsiness stockiness softness

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MeSH    
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Full

**Obesity**  
A status with BODY WEIGHT that is grossly above the recommended standards, usually due to accumulation of excess FATS in the body. The standards may vary with age, sex, genetic or cultural background. In the BODY MASS INDEX, a BMI greater than 30.0 kg/m2 is considered obese, and a BMI greater than 40.0 kg/m2 is considered morbidly obese (MORBID OBESITY).

PubMed search builder options  
[Subheadings:](#)

<input type="checkbox"/> blood	<input type="checkbox"/> enzymology	<input type="checkbox"/> pathology
<input type="checkbox"/> cerebrospinal fluid	<input type="checkbox"/> epidemiology	<input type="checkbox"/> physiopathology
<input type="checkbox"/> chemically induced	<input type="checkbox"/> ethnology	<input type="checkbox"/> prevention and control
<input type="checkbox"/> classification	<input type="checkbox"/> etiology	<input type="checkbox"/> psychology
<input type="checkbox"/> complications	<input type="checkbox"/> genetics	<input type="checkbox"/> radiotherapy
<input type="checkbox"/> congenital	<input type="checkbox"/> history	<input type="checkbox"/> rehabilitation
<input type="checkbox"/> diagnosis	<input type="checkbox"/> immunology	<input type="checkbox"/> surgery
<input type="checkbox"/> diagnostic imaging	<input type="checkbox"/> metabolism	<input type="checkbox"/> therapy
<input type="checkbox"/> diet therapy	<input type="checkbox"/> microbiology	<input type="checkbox"/> urine
<input type="checkbox"/> drug therapy	<input type="checkbox"/> mortality	<input type="checkbox"/> veterinary
<input type="checkbox"/> economics	<input type="checkbox"/> nursing	<input type="checkbox"/> virology
<input type="checkbox"/> embryology	<input type="checkbox"/> parasitology	

- [Appetite Depressants](#)
- [Body Weight](#)
- [Diet, Reducing](#)
- [Skinfold Thickness](#)
- [Lipectomy](#)
- [Anti-Obesity Agents](#)
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[Obesity, Abdominal](#)

[Obesity, Maternal](#)

[Obesity, Metabolically Benign](#)

[Obesity, Morbid](#)

[Pediatric Obesity](#)

[Full](#) ▼

## Child

A person 6 to 12 years of age. An individual 2 to 5 years old is CHILD, PRESCHOOL.

PubMed search builder options

- ☐ Restrict to MeSH Major Topic.
- ☐ Do not include MeSH terms found below this term in the MeSH hierarchy.

Tree Number(s): M01.060.406

MeSH Unique ID: D002648

Entry Terms:

- Children

See Also:

- [Only Child](#)
- [Minors](#)

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[Persons Category](#)

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**Child**

[Child, Preschool](#)

## Attention Deficit Disorder with Hyperactivity

A behavior disorder originating in childhood in which the essential features are signs of developmentally inappropriate inattention, impulsivity, and hyperactivity. Although most individuals have symptoms of both inattention and hyperactivity-impulsivity, one or the other pattern may be predominant. The disorder is more frequent in males than females. Onset is in childhood. Symptoms often attenuate during late adolescence although a minority experience the full complement of symptoms into mid-adulthood. (From DSM-V)

Year introduced: 1984

### Entry Terms:

- Attention Deficit Disorders with Hyperactivity
- ADHD
- Attention Deficit Hyperactivity Disorder
- Hyperkinetic Syndrome
- Syndromes, Hyperkinetic
- Attention Deficit-Hyperactivity Disorder
- Attention Deficit-Hyperactivity Disorders
- Deficit-Hyperactivity Disorder, Attention
- Deficit-Hyperactivity Disorders, Attention
- Disorder, Attention Deficit-Hyperactivity
- Disorders, Attention Deficit-Hyperactivity
- ADDH
- Attention Deficit Hyperactivity Disorders
- Attention Deficit Disorder
- Attention Deficit Disorders
- Deficit Disorder, Attention
- Deficit Disorders, Attention
- Disorder, Attention Deficit
- Disorders, Attention Deficit
- Brain Dysfunction, Minimal
- Dysfunction, Minimal Brain
- Minimal Brain Dysfunction

### Previous Indexing:

- [Brain Damage, Chronic \(1966-1968\)](#)

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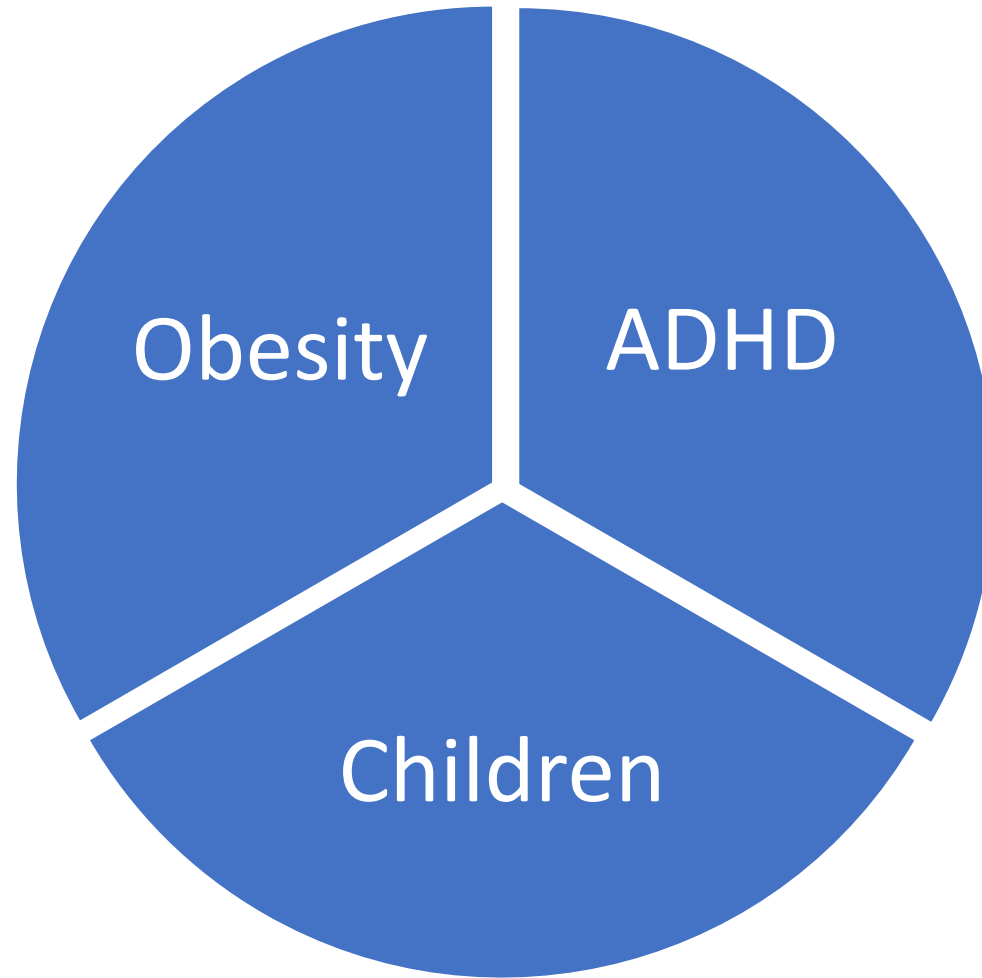
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[Attention Deficit and Disruptive Behavior Disorders](#)

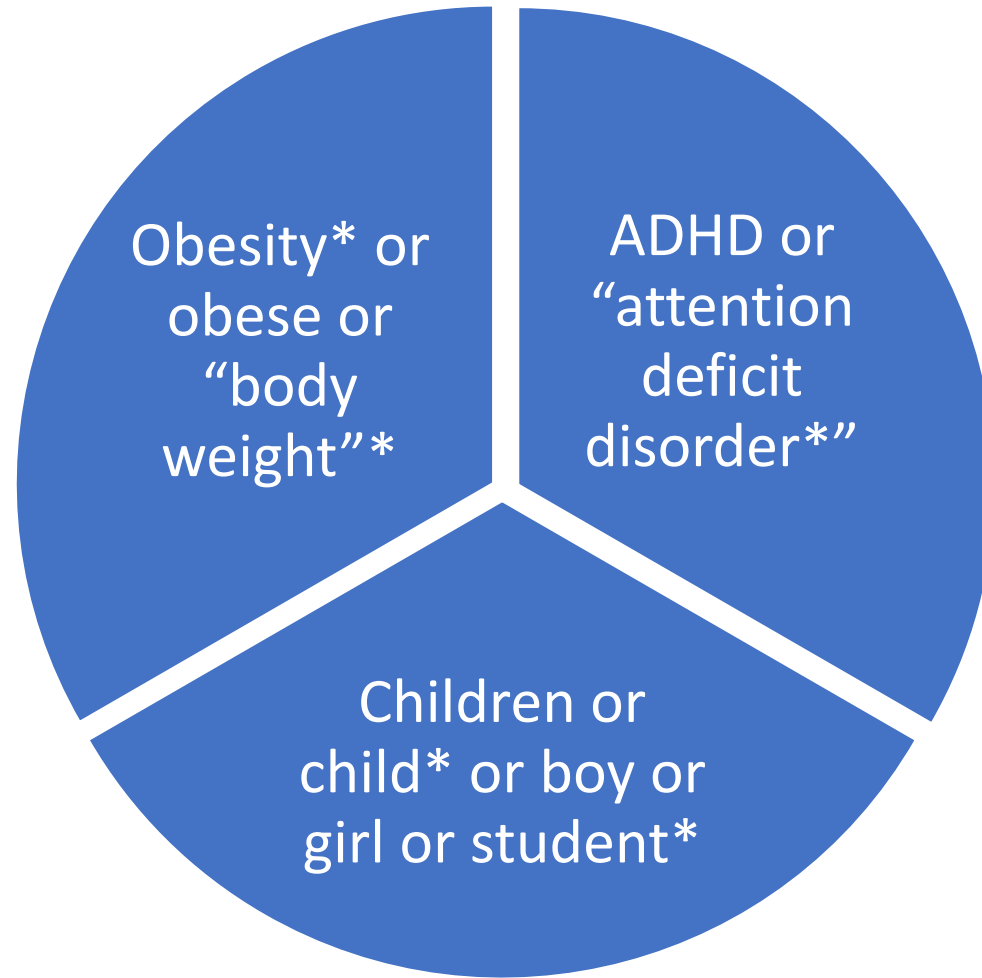
**Attention Deficit Disorder with Hyperactivity**

Is ADHD associated with increased risk of obesity in children?



Currency of information  
Language  
Discipline  
Format

# Is ADHD associated with increased risk of obesity in children?



Currency of information: 1984+

Language: English

Discipline: Health/Psychology

Format: Articles

MEDLINE

MeSH terms\*



# Database searching

# Evidence Synthesis Library Seminar Rapid Review Databases

Is ADHD associated with increased risk of obesity in children?

MEDLINE via Web of Science

PsycINFO

Web of Science Core Collection

# Is ADHD associated with increased risk of obesity in children?

Obesity# or obese or “body weight”#

AND

ADHD or “attention deficit disorder”#

AND

Children or child# or boy or girl or student\*

AND

Language=English ; Date=2000+ ; Format=scholarly peer review articles ; Humans

Currency of information: 2000+

Language: English

Discipline: Health/Psychology

Format: Articles

MEDLINE

MeSH terms #

## DOCUMENTS

## RESEARCHERS

Search in: MEDLINE® ▾

DOCUMENTS

Topic ▾

Example: Neurodegeneration

obesity or obese or "body weight"

✕

And ▾

Topic ▾

Example: Neurodegeneration

ADHD or "attention deficit disorder"

✕

And ▾

Topic ▾

Example: Neurodegeneration

children or child\* or boy or girl or student\*

✕

+ Add row

+ Add date range

Advanced Search

✕ Clear

Search

Search > [Obesity](#) > Results for Obesity or obese or "body weight" (Topic) AND ADHD or "attention deficit disorder" (Topic) and Children or child\* or boy or girl or student\* (Topic)

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- ☐ 1 Health behaviors and obesity among US children with attention deficit hyperactivity disorder by gender and medication use.

[Kim, Juhee; Mutyala, Bala; \(...\); Fernhall, Bo](#)2011 Mar-apr | [Preventive medicine](#) 52 (3-4) , pp.218-22

OBJECTIVE: We examined the levels of physical activity, sedentary behaviors, and obesity among children with attention deficit hyperactivity disorder (ADHD) by gender and medication use and estimated the associations between health behaviors and obesity.

METHODS: Cross-sectional analysis of children 6-17 years-old enrolled in the National Survey of Children's Health 2003 (n=6 ... [Show more](#) Find It @ Brock [Full Text at Publisher](#) ...

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Title ▾

Example: water consum\*

obesity or obese or "body weight" ×

And ▾

MeSH Heading ▾

Example: Clonal evolution

ADHD or "attention deficit disorder" ⚙ ×

And ▾

Age Group ▾

Child: 6-12 years ×

+ Add row

+ Add date range

Advanced Search

× Clear

Search

Search > ... > Results for obesity OR Obes... > Results for obesity OR Obesity (MeSH Heading) AND attention deficit disord...

146 results from MEDLINE® for:

Q obesity OR Obesity (MeSH Heading) and attention deficit disorder OR Attention Deficit Disorder with Hyperactivity (MeSH Heading) and Child: 6-12 years (Age Group)

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Publication Type: Journal Article X

MeSH Headings: Humans X

Languages: English X

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- ☐ 2018 12

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- 1 The influence of preschoolers' emotional and behavioural problems on obesity treatment outcomes: Secondary findings from a randomized controlled trial.

Eiffener, Elodie; Eli, Karin; (...); Nowicka, Paulina

2019-11 | [Pediatric obesity](#) 14 (11) , pp.e12558

BACKGROUND: Few studies have explored the  
OBJECTIVES: To assess emotional and behavioral  
child behaviour and changes in weight status.

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- 2 Key developments in paediatrics.

Barrett, T G

2001-jul | [The Practitioner](#) 245 (1624) , pp.593-5, 598, 601-2

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Results for obesity OR Obesity (MeSH Heading) AND attention deficit disorder OR Attention Deficit Disorder with Hyperactivity (MeSH Heading) AND Child: 6-12 years (Age Group) and 1997 or 1992 or 1987 (Exclude – Publication Years) and Journal Article (Publication Type) and Humans (MeSH Headings) and English (Languages)

Search > ... > Results for obesity OR Obes... > Results for obesity OR Obesity (MeSH Heading) AND attention deficit disord...

146 results from MEDLINE® for:

Q obesity OR Obesity (MeSH Heading) and attention deficit disorder OR Attention Deficit Disorder with Hyperactivity (MeSH Heading)

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- 1 The influence of preschoolers' emotional and behavioural problems on obesity treatment outcomes: Secondary findings from a randomized controlled trial

[Eiffener, Elodie; Eli, Karin; \(...\); Nowicka, Paulina](#)

2019-11 | [Pediatric obesity](#) 14 (11) , pp.e12556

BACKGROUND: Few studies have explored the influence of preschoolers' behavioural problems on obesity treatment. OBJECTIVES: To assess emotional and behavioural problems before and after an obesity intervention and examine relationships between changes in child behaviour and changes in weight status.

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# Evidence Synthesis Library Seminar Rapid Review Databases

Is ADHD associated with increased risk of obesity in children?

MEDLINE via Web of Science

ProQuest Sociology Collection

[Web of Science Core Collection](#)

# Is ADHD associated with increased risk of obesity in children?

Topics: obese\* or “body weight”

AND

Titles: ADHD or “attention deficit\*”

AND

Topics: child\* or boy\* or girl\*

AND

Language=English ; Date=2000+ ; Format=scholarly peer review articles

Currency of information: 2000+  
Language: English  
Format: Articles

Web of Science Core Collection  
No thesuarus

Search &gt; ... &gt; Results for obese\* or "body... &gt; Results for obese\* or "body weight" (Topic) AND ADHD or "attention deficit\* ...

## 134 results from Web of Science Core Collection for:

Q obese\* or "body weight" (Topic) and ADHD or "attention deficit\*" (Title) and child\* or boy\* or girl\* (Topic)

Analyze Results

Citation Report

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&lt; 1 of 3 &gt;

☐ 1 Effect of melatonin on sleep, behavior, and cognition in ADHD and chronic sleep-onset insomnia

205

Citations

[Van Der Heijden, KB; Smits, MG; \(...\); Gunning, WB](#)

Feb 2007 | JOURNAL OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY 46 (2) , pp.233-241

Objective: To investigate the effect of melatonin treatment on sleep, behavior, cognition, and quality of life in children with attention-deficit/hyperactivity disorder (ADHD) and chronic sleep onset insomnia. Method: A total of 105 medication-free children, ages 6 to 12 years, with rigorously diagnosed ADHD and chronic sleep onset insomnia participated in a randomized, double-blind, placebo-co ... [Show more](#)

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[Allen, AJ; Kurlan, RM; \(...\); Spencer, TJ](#)

Dec 27 2005 | NEUROLOGY 65 (12) , pp.1941-1949

Objective: To test the hypothesis that atomoxetine does not significantly worsen tic severity relative to placebo in children and adolescents with attention deficit/hyperactivity disorder (ADHD) and comorbid tic disorders. Methods: Study subjects were 7 to 17 years old, met Diagnostic and Statistical Manual of Mental Disorders-IV criteria for ADHD, and had concurrent Tourette syndrome or chroni ... [Show more](#)

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45

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# Evidence Synthesis Library Seminar Rapid Review Databases

Is ADHD associated with increased risk of obesity in children?

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# Sociological Thesaurus

Search terms:

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Browse terms:

All 0-9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

« Back

 - notes

☐ Obesity 

Related terms:

- ☐ Body Weight
- ☐ Diet
- ☐ Diseases
- ☐ Feeding Practices
- ☐ Health

×

Broader terms:

☐ Physical Abnormalities 

0 terms selected [view](#)

Combine using:

☒ OR ☐ AND ☐ NOT

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# Sociological Thesaurus

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 - notes

☐ Attention Deficit Disorder 

Use term for:

Attention Deficit Hyperactivity Disorder

×

Related terms:

- ☐ Attention
- ☐ Behavior Problems
- ☐ Child Development
- ☐ Cognitive Functioning
- ☐ Impulsiveness
- ☐ Learning Disabilities

## Broader terms:

☐ Disorders 

0 terms selected [view](#)

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# Sociological Thesaurus

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Browse terms:

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 - notes

☒ Children 

Persons aged 24 months to 12 years.



Use term for: Boy/Boys (1963-1985), Girl/Girls (1963-1985)

Related terms:

- ☐ Adolescents
- ☐ Cartoons
- ☐ Child Abuse
- ☐ Child Care Services
- ☐ Child Development
- ☐ Child Labor
- ☐ Child Mortality
- ☐ Child Neglect
- ☐ Child Sex Preferences
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- ☐ Child Support
- ☐ Child Welfare Services
- ☐ Childhood
- ☐ Childrearing Practices
- ☐ Daughters

# Is ADHD associated with increased risk of obesity in children?

Obesity#

AND

ADHD or “attention deficit disorder”#

AND

Children\*# or “child development”# or childhood# or  
“elementary school students”#

AND

Language=English ; Date=2000+ ; Format=scholarly articles

Currency of information: 2000+  
Language: English  
Format: Scholarly Articles

ProQuest Sociology Collection  
Thesaurus Terms #



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Search tips

<input type="text" value="obesity"/>	in	<div>All subjects &amp; indexing – SUBJECT</div>
<div>AND</div>		
<input attention="" deficit="" disorder\""="" type="text" value="ADHD OR \"/>	in	<div>Anywhere except full text – NOFT</div>
<div>AND</div>		
<input \"elementary="" child="" childhood="" development*\"="" or="" school="" students\""="" type="text" value="children* OR \"/>	in	<div>All subjects &amp; indexing – SUBJECT</div>

+ Add a row   - Remove a row



subject(Obesity) AND NOT(ADHD OR attention deficit disorder) AND subject(children OR child development\*) OR childhood OR "elementary school students")



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## 35 results

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Source type


Scholarly Journals (35)

Publication date

2007 - 2022 (years)




☒ Select 1-35 35 Selected items [Clear](#)

- ☒ 1
- 

**Body Mass Index in Girls with and without ADHD in Adulthood**  
Porter, Patricia A; Henry, Laura N; Halkett, Ashley; Hinshaw, Susan P; et al. *Journal of Clinical Child & Adolescent Psychology*; Philadelphia Vol. 51, Iss. 5, (Sep 2022): 688-700.  
...ADHD and trajectories of body mass index (BMI) from childhood to adulthood...utilized longitudinal data from a full sample of 140 girls diagnosed with ADHD...BMI trajectories of girls with ADHD and the comparison sample...

[Abstract/Details](#) [Find Full Text](#)

- ☒ 2
- 

**ADHD subtypes are associated differently with circadian rhythm sleep disturbances, and body mass index in children and adolescents**  
Zerón-Rugério, Maria Fernanda; Carpio-Arias, Tannia Valeria; et al. *European Child & Adolescent Psychiatry*; New York Vol. 30, Iss. 12, (Dec 2021): 1917-1927.  
...(ADHD). The objective was to study the circadian rhythm sleep disturbances...ADHD subtype (combined or inattentive), sleep disturbances and body mass index...and adolescents (60 medication naïve ADHD and 60 controls) were included in a...

[Abstract/Details](#) [Full text - PDF \(875 KB\)](#)

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halo	A Pharmacokinetic Study of Methylphenidate Hydrochloride Multilayer Extended-Release...	Auger et al.
HLSC 3P80	A psycho-genetic study of associations between the symptoms of binge eating disorder ...	Davis et al.
indigenous chemistry	A Randomized Trial of Edvoxetine in Pediatric Patients with Attention-Deficit/Hyperactiv...	Lin et al.
Inman	A Randomized, Double-Blind, Placebo-Controlled, Two-Way Crossover Clinical Trial of O...	Huang et al.
joyce	A Review of Childhood Behavioral Problems and Disorders in the Development of Obesit...	Matheson and Eichen
KINE 2P91	A Review: Associations Between Attention-deficit/hyperactivity Disorder, Physical Activit...	Quesada et al.
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Matt	ADHD as a risk factor for obesity. Current state of research.	Hanc
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physics paper	ADHD is a risk factor for overweight and obesity in children.	Fliers et al.
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Ridley IB Project	ADHD subtypes are associated differently with circadian rhythms of motor activity, sleep...	Zerón-Rugério et al.
subject specialist librarians	ADHD symptoms and insistence on sameness in Prader-Willi syndrome.	Wigren and Hansen
Toughest Job in the Library	ADHD symptoms and maturity - a study in primary school children	Gustafsson et al.
Vicki	ADHD Symptoms and Obesity in Chinese Children and Adolescents: A Longitudinal Stud...	Zhang et al.
My Publications	ADHD symptoms, breast-feeding and obesity in children and adolescents.	Turkoglu et al.
Duplicate Items	Adult attention-deficit hyperactivity disorder and obesity: epidemiological study	Cortese Samuele et al.
Unfiled Items	Adulthood and childhood ADHD in patients consulting for obesity is associated with foo...	Brunault et al.
Trash	Age-dependent neuropsychological deficits and effects of methylphenidate in children ...	Hanisch et al.
	Amphetamine-type medicines: a review of pharmacokinetics, pharmacodynamics, and t...	Mariotti et al.
	An open clinical trial of buspirone in children with attention-deficit hyperactivity disorder	Malhotra and Santosh

# Evidence Synthesis Library Seminar Rapid Review Databases

MEDLINE, Embase, PsycINFO, CINAHL, Web of Science Core Collection

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# Evidence Synthesis Library Seminar Rapid Review Databases

Is ADHD associated with increased risk of obesity in children?

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ProQuest Sociology Collection	35
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	315
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How do you know when you've found the most appropriate research?





Validity

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# Evidence Synthesis Library Seminar Rapid Review Databases

Is ADHD associated with increased risk of obesity in children?

## Inclusion

Scholarly articles  
2000+  
English  
Children 6-12 years of age / grades  
Humans  
Obesity BMI class 1 or 2  
Geography/Setting

## Exclusion

study design / random trials  
primarily social / health indicators  
avoid neurodevelopmental disorders  
avoid genetic disorders  
types of data

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- future
- halo
- HLSC 3P80
- indigenous chemistry
- Inman
- joyce
- KINE 2P91
- maddy ian chem
- Math article
- Matt
- OCULA
- physics paper
- rhea
- Ridley IB Project

Title	Creator
11p14.1 microdeletions associated with ADHD, autism, developmental delay, and obesity.	Shinawi et al.
25-Hydroxvitamin D concentrations are not lower in children with bronchial asthma, ato...	Reinehr et al.
A community study of psychosocial functioning and weight in young children and adol...	Drukker et al.
A Novel Homozygous Selenocysteine Insertion Sequence Binding Protein 2 (SECISBP2, S...	
A Review of Childhood Behavioral Problems and Disorders in the Development of Obesit...	
A Review: Associations Between Attention-deficit/hyperactivity Disorder, Physical Activit...	
ADHD and overweight in boys: cross-sectional study with birth weight as a controlled fa...	
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ADHD as a risk factor for obesity. Current state of research.	
ADHD in childhood predicts BMI and body composition measurements over tim	
ADHD is a risk factor for overweight and obesity in children.	
ADHD symptoms and insistence on sameness in Prader-Willi syndrome.	
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ADHD symptoms, breast-feeding and obesity in children and adolescents.	
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Assessing causality in the association between attention-deficit/hyperactivity disorder a...	
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Association Between ADHD and Obesity: A Systematic Review and Meta-Analysis.	
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Association of Tourette Syndrome and Chronic Tic Disorder With Metabolic and Cardio...	
Associations between attention-deficit/hyperactivity disorder symptoms and eating beha...	

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Item TypeJournal Article

TitleA Review of Childhood Behavioral

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- American Psychological Association (APA) 7th edition
- American Psychological Association (APA) 7th edition (with abstract)
- American Sociological Association (ASA) 6th edition
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# Inclusion

Scholarly articles

2000+

English

Children 6-12 years of age / grades

Humans

Obesity BMI class 1 or 2

Geography/Setting

Association between symptoms of attention-deficit/hyperactivity disorder and bulimic behaviors in a clinical sample of severely obese adolescents.

Preliminary evidence suggests a comorbidity between attention-deficit/hyperactivity disorder (ADHD) and obesity. This study was carried out to identify the clinical characteristics of obese adolescents with a higher probability of ADHD and advance the understanding of the potential factors underlying the comorbidity between obesity and ADHD. We evaluated the association between ADHD symptoms and bulimic behaviors, depressive and anxiety symptoms, degree of obesity, pubertal stage, age and gender in a clinical sample of obese adolescents. DESIGN: Cross-sectional study. SUBJECTS: Ninety-nine severely obese adolescents aged 12-17 years. MEASUREMENTS: Subjects filled out the Bulimic Investigatory Test, Edinburgh, the Beck Depression Inventory and the State-Trait Anxiety Inventory for Children. Their parents completed the Conners Parent Rating Scale, which assesses ADHD symptoms. The degree of overweight was expressed as body mass index-z score. Puberty development was clinically assessed on the basis of Tanner stages. RESULTS: Bulimic behaviors were significantly associated with ADHD symptoms after controlling for depressive and anxiety symptoms. The degree of overweight, pubertal stage, age and gender were not significantly associated with ADHD symptoms. CONCLUSION: Obese adolescents with bulimic behaviors may have a higher probability to present with ADHD symptoms independently from associated depressive or anxiety symptoms. The degree of overweight, pubertal stage, age and gender might not be useful for detecting obese adolescents with ADHD symptoms. Therefore, we suggest systematic screening for ADHD in obese adolescents with bulimic behaviors. Further studies are needed to understand which specific dimension of ADHD primarily accounts for the association with bulimic behaviors. Future research should also investigate the causal link between bulimic behaviors and ADHD and explore potential common neurobiological alterations. This may lead to a better understanding of the effectiveness of stimulants for the treatment of bulimic behaviors in obese subjects.

## Exclusion

study design / random trials

primarily social / health indicators

Avoid neurodevelopmental disorders

Avoid genetic disorders

Types of data

Association between symptoms of attention-deficit/hyperactivity disorder and bulimic behaviors in a clinical sample of severely obese adolescents.

Preliminary evidence suggests a comorbidity between attention-deficit/hyperactivity disorder (ADHD) and obesity. This study was carried out to identify the clinical characteristics of obese adolescents with a higher probability of ADHD and advance the understanding of the potential factors underlying the comorbidity between obesity and ADHD. We evaluated the association between ADHD symptoms and bulimic behaviors, depressive and anxiety symptoms, degree of obesity, pubertal stage, age and gender in a clinical sample of obese adolescents. DESIGN: Cross-sectional study. SUBJECTS: Ninety-nine severely obese adolescents aged 12-17 years. MEASUREMENTS: Subjects filled out the Bulimic Investigatory Test, Edinburgh, the Beck Depression Inventory and the State-Trait Anxiety Inventory for Children. Their parents completed the Conners Parent Rating Scale, which assesses ADHD symptoms. The degree of overweight was expressed as body mass index-z score. Puberty development was clinically assessed on the basis of Tanner stages. RESULTS: Bulimic behaviors were significantly associated with ADHD symptoms after controlling for depressive and anxiety symptoms. The degree of overweight, pubertal stage, age and gender were not significantly associated with ADHD symptoms. CONCLUSION: Obese adolescents with bulimic behaviors may have a higher probability to present with ADHD symptoms independently from associated depressive or anxiety symptoms. The degree of overweight, pubertal stage, age and gender might not be useful for detecting obese adolescents with ADHD symptoms. Therefore, we suggest systematic screening for ADHD in obese adolescents with bulimic behaviors. Further studies are needed to understand which specific dimension of ADHD primarily accounts for the association with bulimic behaviors. Future research should also investigate the causal link between bulimic behaviors and ADHD and explore potential common neurobiological alterations. This may lead to a better understanding of the effectiveness of stimulants for the treatment of bulimic behaviors in obese subjects.

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2000+  
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Children 6-12 years of age / grades  
Humans  
Obesity BMI class 1 or 2  
Geography/Setting

EXCLUSION

study design / random trials  
primarily social / health indicators  
avoid neurodevelopmental disorders  
avoid genetic disorders  
types of data

☐ #103 - Porfirio 2015

Role of ADHD symptoms as a contributing factor to obesity in patients with MC4R

Porfirio, MC; Giovinazzo, S; Cortese, S; Giana, G; Lo-Castro, A; Mouren, MC; Curatolo, P; Purper-Ouakil, D  
MEDICAL HYPOTHESES 2015;84(1):4-7  
2015  
DOI: [10.1016/j.mehy.2014.11.004](https://doi.org/10.1016/j.mehy.2014.11.004)

Abstract


Besides the crucial role of genetic susceptibility in the development of early-onset obesity, it has been shown that feeding behavior could contribute to increased body weight. A significant association between obesity/overweight and ADHD has been reported, suggesting that these two conditions, despite their heterogeneity, might share common molecular pathways. Although the co-occurrence of obesity and ADHD is increasingly supported by empirical evidence, the complex pathogenetic link between these two conditions is still unclear. Here, we focus on the relationship between MC4R gene mutations and ADHD in children with early-onset obesity. Mutations in the gene MC4R lead to the most common form of monogenic obesity. We hypothesize that dysregulated eating behavior in a subset of patients with MC4R mutation might be due to comorbid ADHD symptoms, underpinned by abnormal reward mechanisms. Therefore, we speculate that it is possible to prevent obesity in a subset of patients with MC4R mutation, even if these patients are genetically programmed to "be fat", via an appropriate treatment of ADHD symptoms. We hope that our paper will stimulate further studies testing if the early screening for ADHD symptoms and their appropriate treatment may be an effective way to prevent obesity in a subset of children with MC4R mutation. (C) 2014 Elsevier Ltd. All rights reserved.

No



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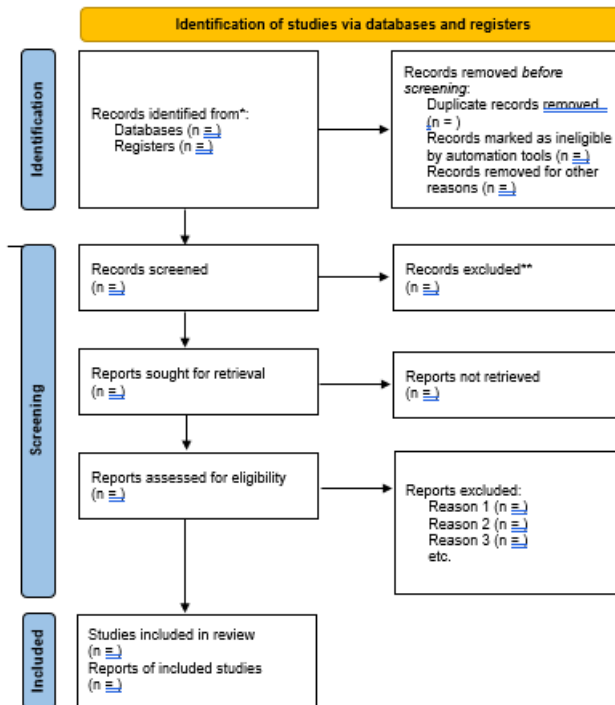
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PRISMA 2020 flow diagram for new systematic reviews which included searches of databases and registers only



\*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).

\*\*If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;**372**:n71. doi: 10.1136/bmj.n71

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Dell'Agnello, G., Maschietto, D., Bravaccio, C., Calamoneri, F., Masi, G., Curatolo, P., Besana, D., Mancini, F., Rossi, A., Poole, L., Escobar, R., Zuddas, A., & LYCY Study Grp. (2009). Atomoxetine hydrochloride in the treatment of children and adolescents with attention-deficit/hyperactivity disorder and comorbid oppositional defiant disorder: A placebo-controlled Italian study. EUROPEAN NEUROPSYCHOPHARMACOLOGY, 19(11), 822–834. <https://doi.org/10.1016/j.euroneuro.2009.07.008>



Granato, M. F., Ferraro, A. A., Lellis, D. M., & Casella, E. B. (2018). Associations between Attention-Deficit Hyperactivity Disorder (ADHD) Treatment and Patient Nutritional Status and Height. Behavioural Neurology, 2018, 7341529–7341529. <https://doi.org/10.1155/2018/7341529>

Guner, S., Uneri, O., Sekmen, E., Goker, Z., Cop, E., & Hekim, O. (2021). Assessment of Obesity, Psychiatric Comorbidity and Food Addiction in Children and Adolescents with Attention Deficit and Hyperactivity Disorder. PSYCHIATRY AND BEHAVIORAL SCIENCES, 11(2), 104–114. <https://doi.org/10.5455/PBS.20200612044606>

Yim, G., Roberts, A., Ascherio, A., Wypij, D., Kioumourtoglou, M., & Weisskopf, M. (2021). Association Between Periconceptional Weight of Maternal Grandmothers and Attention-Deficit/Hyperactivity Disorder in Grandchildren. JAMA NETWORK OPEN, 4(7). <https://doi.org/10.1001/jamanetworkopen.2021.18824>

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10.1016/j.euroneuro.2009.07.008

Cite

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[HTML] Atomoxetine hydrochloride in the treatment of children and adolescents with attention-deficit/hyperactivity disorder and comorbid oppositional defiant disorder ...

G Dell'Agnello, D Maschietto, C Bravaccio... - European ..., 2009 - Elsevier

OBJECTIVE: The primary aim of this study was to assess the efficacy of atomoxetine in improving ADHD and ODD symptoms in paediatric patients with ADHD and comorbid oppositional defiant disorder (ODD), non-responders to previous psychological intervention with parent support. METHODS: This was a multicentre, randomised, placebo-controlled trial conducted in patients aged 6–15 years, with ADHD and ODD diagnosed according to the DSM-IV criteria by a structured clinical interview (K-SADS-PL). Only subjects who are non ...

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## Atomoxetine hydrochloride in the treatment of children and adolescents with attention-deficit/hyperactivity disorder and comorbid oppositional defiant disorder: A placebo-controlled Italian study

Grazia Dell'Agnello<sup>a</sup>, Dino Maschietto<sup>b</sup>, Carmela Bravaccio<sup>c</sup>,  
Filippo Calamoneri<sup>d</sup>, Gabriele Masi<sup>e</sup>, Paolo Curatolo<sup>f</sup>, Dante Besana<sup>g</sup>,  
Francesca Mancini<sup>a</sup>, Andrea Rossi<sup>a</sup>, Lynne Poole<sup>h</sup>,  
Rodrigo Escobar<sup>i</sup>, Alessandro Zuddas<sup>j,\*</sup>  
for the LYCY Study Group

<sup>a</sup> Medical Department, Eli Lilly Italia, Italy

<sup>b</sup> Operative Unit of Child Neuropsychiatry, Azienda USL n 10 Veneto Orientale, San Donà di Piave, Venezia, Italy

<sup>c</sup> Department of Pediatrics, University of Naples "Federico II", Italy

<sup>d</sup> Clinic of Child Neuropsychiatry, University Policlinic of Messina, Italy

<sup>e</sup> Department of Child Neuropsychiatry, IRCCS Fondazione Stella Maris, Calambrone, Pisa, Italy

<sup>f</sup> Department of Child Neuropsychiatry, Tor Vergata University of Rome, Italy

<sup>g</sup> Operative Structure of Child Neuropsychiatry, Hospital of Alessandria, Italy

<sup>h</sup> Eli Lilly and Co. UK

<sup>i</sup> European Medical Department, Eli Lilly and Co. Alcobendas, Madrid, Spain

<sup>j</sup> Department of Neuroscience, Section of Child Neuropsychiatry, University of Cagliari, Italy

Received 3 January 2009; received in revised form 2 July 2009; accepted 23 July 2009

### KEYWORDS

Atomoxetine;  
Attention-deficit/  
hyperactivity disorder;  
Oppositional defiant  
disorder

### Abstract

**Objective:** The primary aim of this study was to assess the efficacy of atomoxetine in improving ADHD and ODD symptoms in paediatric patients with ADHD and comorbid oppositional defiant disorder (ODD), non-responders to previous psychological intervention with parent support.  
**Methods:** This was a multicentre, randomised, placebo-controlled trial conducted in patients aged 6–15 years, with ADHD and ODD diagnosed according to the DSM-IV criteria by a structured

\* Corresponding author. Centre for Pharmacological Therapies in Child and Adolescent Neuropsychiatry, Department of Neuroscience, University of Cagliari, via Ospedale, 46, 09124 Cagliari, Italy. Tel.: +39 070 609 3509/3510; fax: +39 070 669591.  
E-mail address: azuddas@unica.it (A. Zuddas).



## PRISMA 2009 Checklist

Section/topic	#	Checklist Item	pg #
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators. (this component would typically have 2 or more individuals independently searching and sometime includes contacting investigators – yours will not, so it's fairly simple)	
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made. (i.e., what results, variables, and/or study characteristics are you pulling from the articles to report? [eg in your table])	
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis. (i.e. how will you assess the risk of bias in the studies? consider biases related to study design, sample/recruitment procedures, generalizability of sample, group assignment [randomization, blinding], measurement biases, confounding, funding, length of follow-up, etc.)	
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., $I^2$ ) for each meta analysis.	
Risk of bias <b>across studies</b>	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies, language bias, etc.).	
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta regression), if done, indicating which were pre specified.	
<b>RESULTS /30</b> *Must include flow diagram and results summary table (NOTE: report results in the table and diagram <b>AND</b> describe them in the written paper). Results are now what you found from your process – your search results, the characteristics of the studies that you included in your review, the results of these studies in answer to your research question, risk of bias in those studies, and risk of bias across studies.			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a <b>flow diagram</b> . (Results of your search – how many results, how many screened, how many excluded and way, etc. You must include a flow diagram, and outline this in your written discussion).	
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations. (ie what do the studies look like that you included in the review? Include Table <b>AND</b> describe in writing)	
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12). (assess each study for risk of bias – see item 12 methods for examples to consider; describe strengths/limitations of <b>individual</b> studies and commonalities in these individual study risk of biases across them)	
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) <b>effect estimates and confidence intervals</b> , ideally with a forest plot. (ie what did the studies find in answer to your research question?)	
Synthesis of results	21	Present results of each meta analysis done, including confidence intervals and measures of consistency.	



Citation	Study characteristic 1	Study characteristic 2	Study characteristic 3	Risk of Bias		
<u>Dell'Agnello, G., Maschietto, D., Bravaccio, C., Calamoneri, F., Masi, G., Curatolo, P., Besana, D., Mancini, F., Rossi, A., Poole, L., Escobar, R., Zuddas, A., &amp; LYCY Study Grp. (2009). Atomoxetine hydrochloride in the treatment of children and adolescents with attention-deficit/hyperactivity disorder and comorbid oppositional defiant disorder: A placebo-controlled Italian study. EUROPEAN NEUROPSYCHOPHARMACOLOGY, 19(11), 822–834</u>						
<u>Granato, M. F., Ferraro, A. A., Lellis, D. M., &amp; Casella, E. B. (2018). Associations between Attention-Deficit Hyperactivity Disorder (ADHD) Treatment and Patient Nutritional Status and Height. Behavioural Neurology, 2018, 7341529–7341529.</u>						
<u>Guner, S., Uneri, O., Sekmen, E., Goker, Z., Cop, E., &amp; Hekim, O. (2021). Assessment of Obesity, Psychiatric Comorbidity and Food Addiction in Children and Adolescents with Attention Deficit and Hyperactivity Disorder. PSYCHIATRY AND BEHAVIORAL SCIENCES, 11(2), 104–114</u>						
<u>Yim, G., Roberts, A., Ascherio, A., Wypij, D., Kivimäki, M., &amp; Weisskopf, M. (2021). Association Between Periconceptional Weight of Maternal Grandmothers and</u>						



What bias was introduced to your rapid review?



## PRISMA 2009 Checklist

Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15 for examples; why might the results of your group of articles be biased? Are certainly results more likely to be included?)	
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta regression (see Item 16)).	
<b>DISCUSSION /15</b> (e.g., answer to your research question; overall main conclusions and limitations or gaps identified in research reviewed; next steps/future research; limitations of your rapid review)			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers). (overall – what did your rapid review find? What do these studies say in answer to your research question? And what is the strength of this evidence available? What is the relevance – ie what do these results mean to those who could use this evidence?)	
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias). (i.e., limitations overall of the studies that you reviewed, AND potential limitations of your rapid review – think about if/how our rapid review might have missed key evidence and why? Think about what makes a rapid review 'rapid' relative to a Systematic Review?)	
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research. (sum up what the evidence says and means; what are implications for future research based on limitations identified in the research)	
<b>FUNDING</b>			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit: [www.prisma-statement.org](http://www.prisma-statement.org).

	Aschwanden 2001	Blattler 2003	Feng 2011	Huang 2010	Isma 2007	Junger 2006	Liu 2013	Manganaro 2008	Rahman 2009	Romera 2006	Romera 2008	Schellong 1999	Trujillo-santos 2005
Random sequence generation (selection bias)	?	?		+	?	+	?		?	?	?	?	
Allocation concealment (selection bias)	+	+		?	?	+	?		?	?	+	?	
Blinding of participants and personnel (performance bias)	?	-		-	-	-	-		-	-	-	-	
Blinding of outcome assessment (detection bias)	+	+		?	+	+	?		-	?	?	+	
Incomplete outcome data (attrition bias)	+	+		-	+	+	+		+	+	+	+	
Selective reporting (reporting bias)	+	+		+	+	+	+		+	+	+	+	
Other bias													

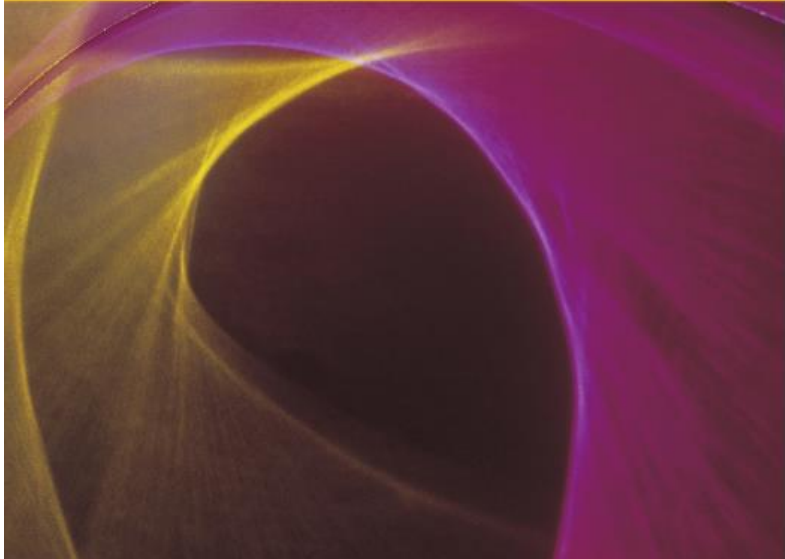
Image: Liu, Z. et al. (2015): Summary of risk of bias for RCTs (RevMan 5.3).  
PLOS ONE. Figure. <https://doi.org/10.1371/journal.pone.0121388.g002>

ISSUES IN CLINICAL CHILD PSYCHOLOGY

# Handbook of Evidence-Based Therapies for Children and Adolescents Bridging Science and Practice

Edited by

Ric G. Steele, T. David Elkin, and  
Michael C. Roberts



## **Evidence-Based Therapies for Children and Adolescents with Eating Disorders**

**DAVID H. GLEAVES and JANET D. LATNER**

*"Is evidence-based treatment of anorexia nervosa possible?",  
the answer must be 'Barely'."*

(Fairburn, 2005, p. S29)

The principal eating disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) are anorexia nervosa (AN), bulimia nervosa (BN), and eating disorder not otherwise specified (EDNOS), which may designate binge eating disorder (BED) or atypical variants of AN or BN. As with adults, the atypical variants of eating disorders appear to be more common than the specified disorders (Kjelsås et al., 2004). In earlier versions of the DSM (up to the 3rd edition, revised), the eating disorders were listed within the *Disorders usually first evident in infancy, childhood, or adolescence* section. Given their prominence among adults, they were moved to their own section in the most recent edition. However, their common origin in childhood should not be forgotten and is the focus of this chapter.

Obesity is also a common eating-related problem among children and adolescents, and there are also several eating-/feeding-related problems that are usually first diagnosed in infancy or early childhood and are thus included in that section of the DSM-IV. These are pica, rumination disorder, and feeding disorder of infancy or early childhood (sometimes referred to as failure to thrive). In this chapter, we will focus on AN and BN and somewhat on BED. Pediatric obesity is covered by Johnston and Tyler (Chapter 20). Given that we will focus largely on treatment rather than

---

DAVID H. GLEAVES • University of Canterbury and JANET D. LATNER • University of Hawaii

# Epilogue

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NEW EDITION

# TOXIC CHILDHOOD

HOW THE MODERN WORLD IS  
DAMAGING OUR CHILDREN AND  
WHAT WE CAN DO ABOUT IT



SUE PALMER  
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## CONTENTS

Acknowledgments	ix
Preface to the second edition	xi
Introduction	1
Chapter One: Food For Thought	22
Chapter Two: Out To Play	51
Chapter Three: Time For Bed	87
Chapter Four: It's Good To Talk	112
Chapter Five: We Are Family	148
Chapter Six: Who's Looking After The Children?	182
Chapter Seven: The Best Days Of Their Lives	212
Chapter Eight: The Word On The Street	247
Chapter Nine: The Electronic Village	282
Chapter Ten: Manners Maketh Man	332
Conclusion: Detoxing Childhood	362
Notes and References	375
Bibliography	428
Index	435

**A BEHAVIOURAL GENETIC MODEL OF THE MECHANISMS UNDERLYING THE  
LINK BETWEEN OBESITY AND DIMENSIONAL MEASURES OF ATTENTION-  
DEFICIT/HYPERACTIVITY DISORDER (ADHD)**

**KAREN A. PATTE**

A DISSERTATION SUBMITTED TO  
THE FACULTY OF GRADUATE STUDIES  
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
FOR THE DEGREE OF  
DOCTOR OF PHILOSOPHY

GRADUATE PROGRAM IN KINESIOLOGY AND HEALTH SCIENCE,  
YORK UNIVERSITY,  
TORONTO, ON

August 2015

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FLORIDA INTERNATIONAL UNIVERSITY

Miami, Florida

A MODEL FOR THE ASSOCIATION BETWEEN ATTENTION-DEFICIT/  
HYPERACTIVITY DISORDER AND OBESITY: EFFECTS OF PHYSICAL  
ACTIVITY, SEDENTARY BEHAVIOR, GENDER, AND MEDICATION

A dissertation submitted in partial fulfillment of

the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

PUBLIC HEALTH

by

Danielle Quesada

2018

**Introduction**

Over the past three decades, attention-deficit/hyperactivity disorder (ADHD) and obesity have both become conditions of great concern for public health. Affecting the lives of children, adolescents and adults. ADHD affects an estimated 6.4 million children and adolescents in the United States (Visser et al., 2014); with an estimated economic burden ranging from \$143-\$266 billion dollars per year. Similarly, obesity affects approximately 12.7 million children and adolescents in the U.S. with an estimated economic burden ranging from \$147- \$330 billion dollars per year (Ogden et al., 2015).

ADHD and obesity are both growing epidemics, negatively affecting the health and well being of children and adolescents. ADHD is defined as having impairing, excessive levels of hyperactivity, impulsivity and inattention (American Psychiatric Association, 2013). These symptoms can affect a child's behavior, self- esteem and social development (American Psychiatric Association, 2013). Consequently, having deleterious effects on the quality of life of a child. A theoretical framework for ADHD posits that those with ADHD are afflicted by deficits in the catecholaminergic system which affects a person's executive functions. Executive functions in turn regulate impulsivity, inhibitory control and the ability to focus (Diamond, 2013)

Obesity is defined as having a body mass index (BMI) at or above the 95th percentile for children and adolescents of the same age and sex (Barlow, 2007). Obesity is associated with the development of chronic diseases, such as type-2 diabetes and certain types of cancer (Gallagher et al. 2015; Fagot-Campagna et al., 2000). In addition, children and adolescents who are overweight or obese are more likely to suffer from



# the ADHD REPORT

Russell A. Barkley & Associates

Volume 22

Number 5

ISSN 1065-8025

August 2014

## ADHD, Obesity, and Eating Pathology

Russell A. Barkley, Ph.D.

The scientific literature on ADHD, obesity, and eating pathologies has increased substantially in the past decade. What is currently known about the relationship of ADHD and problems with growth, particularly with weight and associated eating issues? This article will review this literature. What is rather fascinating here, particularly in regard to obesity and eating pathologies, is that the past 40 years have been witness to the development of a trait-by-environmental resource interaction (impulsivity x junk food availability) that has resulted in a marked increase in these eating problems in association with ADHD in the current generation of children—not evident in prior generations. I will discuss this iteration below.\*

### OBESITY AND CHILD ADHD

For years, ADHD was not thought to be associated with problems of height, weight, or physical growth apart from concerns that stimulant treatment of the disorder could be associated with growth delay. Indeed, if there were an association of the disorder with weight, it was clinically conjectured to be a negative one due to the increased activity levels of children with ADHD that one would expect would result in greater calorie expenditure and hence

a lower body mass index (BMI). One earlier study from 18 years ago examined a sample of 124 ADHD children and adolescents for the presence of growth deficits in height and weight (Spencer et al., 1996). No evidence was found of weight deficits in the children with ADHD, even though 89% of the sample had been treated with stimulant medications, drugs thought to result in reductions in weight. There were small but significant deficits in height in the children with ADHD compared to the control group but not between the adolescents with ADHD and their control group, implying that any growth delay may be time limited to childhood. These height deficits were not related to treatment with stimulant medications. The authors

concluded that ADHD itself might be associated with temporary deficits in growth in height in childhood through mid-adolescence, apart from any linkage to stimulant medication treatment, which may no longer be evident by late adolescence.

In contrast, three more recent studies suggest excess BMI or frank obesity in current children with ADHD. For instance, in a large study of more than 7,000 children in France, medication-naïve children with ADHD were somewhat taller and heavier than typical children while no such differences were evident in adolescents with ADHD (Faraone, Lecentreux, & Konofal, 2011). The authors speculated that this might reflect a problem with growth regulation in children with the

\*This article, updated with recent studies, is adapted in part from a chapter on health and related impairments that will appear in the fourth edition of my upcoming textbook on ADHD (Barkley, in press).

### Contents

ADHD, Obesity, and Eating Pathology, 1 • Stimulant Side

Effects and the D1/D2 Receptor Gene Activity, 6 • Research Findings, 8

NOTICE TO NON-PROFESSIONALS The information contained in this newsletter is not intended as a substitute for consultation with health care professionals.

FOCUS ON  
Health

## When Children EAT What They SEE

Dr. David Ludwig talks about the negative influence TV commercials have on young children's diets, and what you can do to counteract the messages

According to the National Center for Health Statistics, more than one in five children in the United States are overweight. And the problem is creeping downward on the age scale, threatening even preschool children. At the same time, type 2 diabetes—once called adult-onset diabetes—is affecting children as young as 4, while attention deficit hyperactivity disorder (ADHD) is also on the rise. Are the problems linked? David Ludwig, M.D., Ph.D., director of the Optimal Weight for Life program at Children's Hospital Boston, thinks they may be. He lays the blame squarely on diets heavy

in processed and fast foods—a situation made worse by the constant barrage of TV commercials that make bad foods look so good to kids.

Young children are particularly vulnerable to media messages, as this is the age at which they learn eating habits that will stay with them for life. The key, he says, is to send your own messages about smart eating by making healthy choices and adopting good habits.

**Parent & Child: How much influence do TV commercials really have on young children's diets? It's clear children aren't making food choices on their own.**

**DR. LUDWIG:** While it's true that parents control what young children eat, children are nonetheless absorbing messages from TV. You can't underestimate the nag factor, when parents give in and buy stuff

that's bad for their children. Unhealthy foods and snacks are presented to kids as being cool, appealing, and desirable. And once they do go to school, they'll be trading foods they brought from home, and seeing the "cool" stuff other kids have.

**Parent & Child: So what can parents and teachers do to help?**

**DR. LUDWIG:** If you start early and use this time to teach good eating habits, you can help prevent problems. By the time a child becomes overweight and parents become alarmed, food habits are already well established, and parent-child power struggles can arise.

Young children need to learn about a healthful diet and lifestyle from the people who love them and who have their best interests at heart. Children imitate adult behavior. Parents, in particular,

should not only be supportive but should also live a healthful lifestyle that includes eating nutritious foods and getting regular exercise.

**Parent & Child: What contributes to poor eating habits and unhealthy lifestyles?**

**DR. LUDWIG:** Families are busy. Children have less opportunity to see their parents preparing and eating nutritionally sound meals. Research shows that when meals are not eaten at home, the nutritional quality of the food goes down, and the number of calories consumed goes up.

Kids are eating more junk than they used to. Take fast food, for instance: During any given week, three out of four children eat a fast-food meal one or more times a day. Rates of fast-food consumption may be lower in younger children, but again, the youngest children are laying down habits that will take hold later. Soda is another example: In the last two decades, soft-drink consumption has gone up threefold. Kids used to drink three servings of milk for every serving of soda. Now those numbers are reversed.

**Parent & Child: How big a role does lack of physical activity play in childhood obesity?**

**DR. LUDWIG:** You can partly blame a lack of exercise, but I think that incessant TV commercials are a bigger offender. The

CORBIS

# Why Experts Are Urging Swifter Treatment for Children With Obesity

The New York Times

January 27, 2023 Friday 13:52 EST

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**Section:** HEALTH

**Length:** 1552 words

**Byline:** Gina Kolata

**Highlight:** Growing research has shown that intensive interventions are needed, scientists say. Here is why their advice is changing.

## Body

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Growing research has shown that intensive interventions are needed, scientists say. Here is why their advice is changing.

The American Academy of Pediatrics recently issued new guidelines for treating the more than 14 million children and adolescents with obesity in the United States. The recommendations came as a surprise to many parents, and to some experts, as they encourage vigorous behavioral interventions even for very young children, as well as drug treatment or surgery for adolescents.

The guidelines spring from a scientific understanding of obesity that has been evolving for decades. Obesity is a risk factor for a number of disorders, including Type 2 diabetes, high blood pressure, joint and back pain, and several cancers. Treating the problem as early as possible may help prevent a lot of misery.

Here are answers to some questions about pediatric obesity research and why experts are now advising aggressive treatment.

What do the new guidelines say about the causes of obesity?

The A.A.P. recommendations stress that obesity is not just a consequence of poor eating habits and a lack of exercise. Obesity is a chronic disease with many intertwined causes, including genetics.

Researchers now know that obesity is one of the most strongly inherited traits. Studies conducted decades ago showed that identical twins reared apart usually grow up to have similar body shapes and weights. Adopted children tend to have the same shapes and weights as their biological parents.

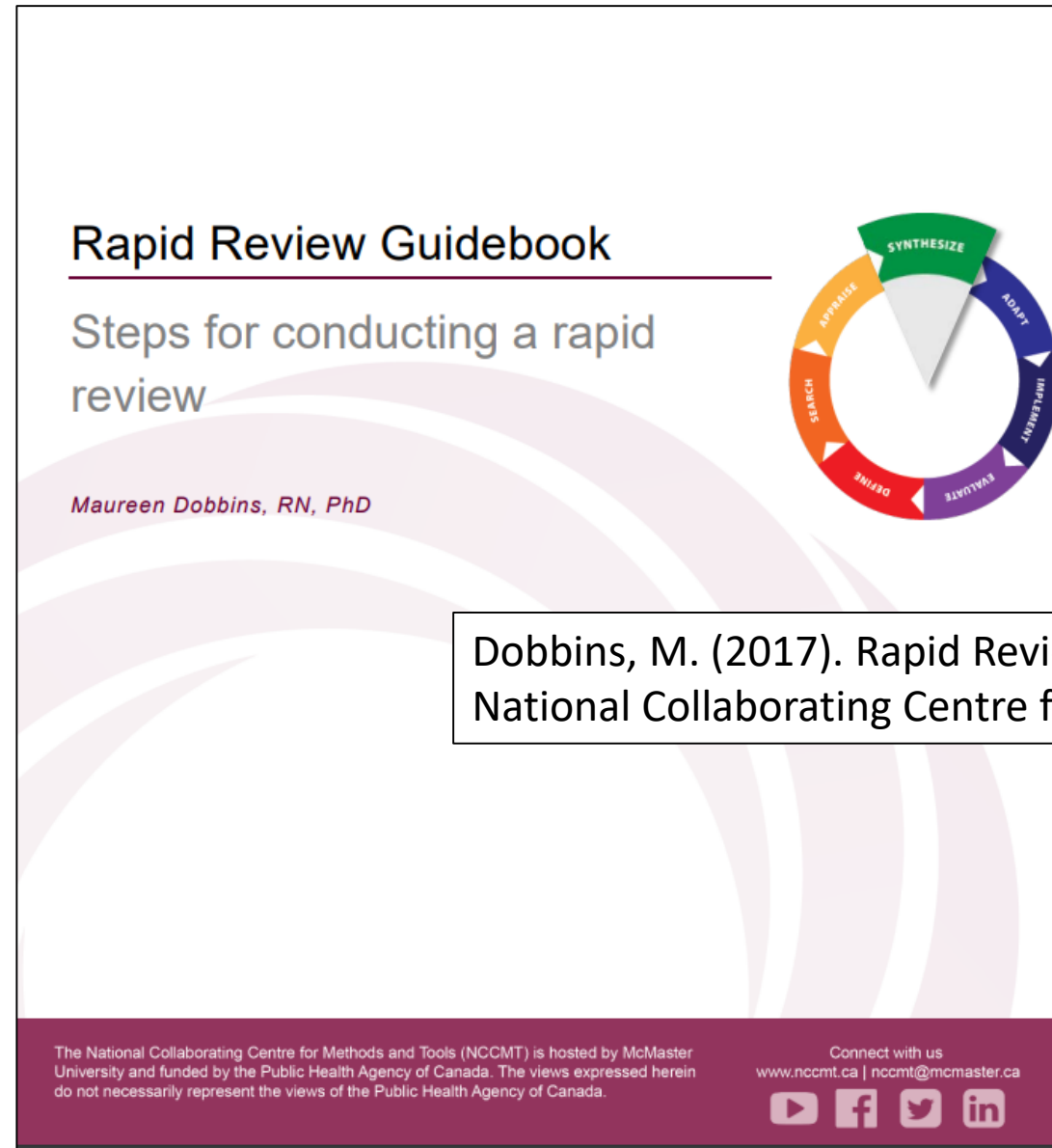
A genetic predisposition sets the stage for some children to gain weight in an environment in which food — often poor-quality food — is everywhere. And weight gain can become a vicious cycle.

Children and adolescents with obesity often experience teasing and bullying, which, the A.A.P. committee wrote, contribute to “binge eating, social isolation, avoidance of health care services and decreased physical activity, further complicating the health trajectory.”

How do scientists define overweight and obesity?

They are defined by body mass index, a measure of weight and height. (It is an imperfect measure; many muscular athletes, for example, have high B.M.I.s but are in excellent shape.)





Dobbins, M. (2017). Rapid Review Guidebook. Hamilton, ON: National Collaborating Centre for Methods and Tools.

# Evidence Synthesis Library Seminar Learning Outcomes

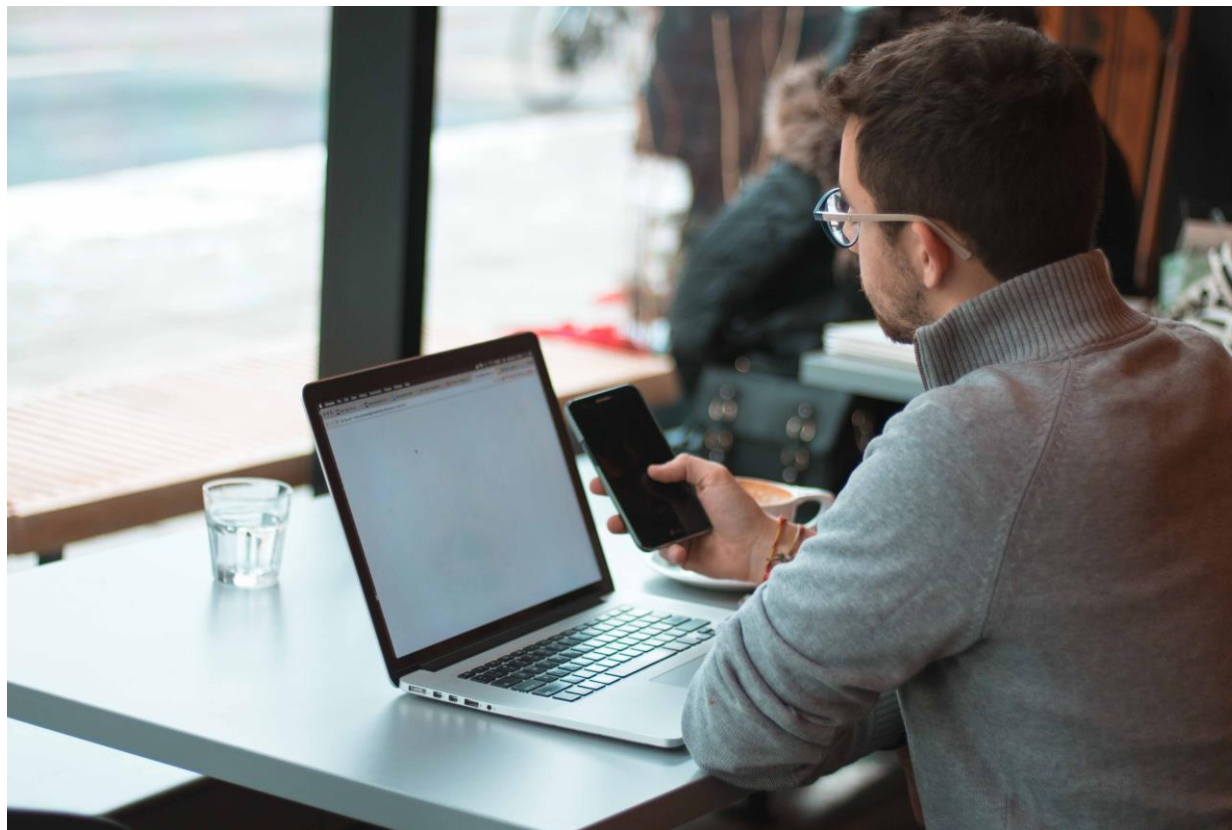
- Understand the importance of evidence synthesis when critically evaluating health issues
- Synthesis, evaluate, communicate, and comment on child health research issues
- Note the value of different evidence synthesis reviews and where rapid reviews fit in
- How best to select appropriate scholarly databases
- The importance of thinking like each database to get the best results
- Screening results for eligibility using inclusion/exclusion criteria
- Identifying emergent themes and writing up results
- Recognize the value of zoterobib and Zotero citation management software
- Documenting findings using PRISMA reporting guidelines and references
- Knowing where and how to get help

# TIPS

- Start early – searching and evaluating resources is an iterative process
- Invest in using zotero bib and Zotero citation management software
- Follow course assignment guidelines and instructions
- Some digital resources work best on- vs. off-campus access
- Lean on colleagues when appropriate
- Book a consultation if needed
- Email Ian or the library at any time

Become:           PubMed certified  
                      zotero bib frequent user  
                      Zotero enabled  
                      Evidence synthesis savvy





Man sitting near table with laptop photo  
by [Joseph Frank](#) on [Unsplash](#)

# Where can I get help with seeking information?

Brock Library Health Sciences Research Guide

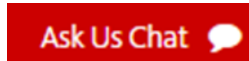
<https://researchguides.library.brocku.ca/HLSC>

Email the Library

[libhelp@brocku.ca](mailto:libhelp@brocku.ca)

Ask Us Chat service

<https://brocku.ca/library/chat/>



Book a Consultation

<https://calendar.library.brocku.ca/appointments/researchconsultation>





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